

OHIO STATE LAW JOURNAL

Volume 53, Number 5, 1992

The Code of Perfect Pregnancy: At the Intersection  
of the Ideology of Motherhood, the Practice of  
Defaulting to Science, and the Interventionist  
Mindset of Law

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## I. INTRODUCTION

Thou shalt obey doctor's orders . . .

Thou shalt not partake of alcohol or drugs potentially harmful to the fetus . . .

Thou shalt do whatever the state deems necessary during pregnancy to produce  
a healthy baby . . .

Thou shalt be a Good Mother.

These commands issue from the Code of Perfect Pregnancy, which is ostensibly premised on the social good of "fetal interests." There is no Code of

Perfect Pregnancy in the strictly legal sense. However, there is outstanding the idea and practice of controlling women with regard to conception, gestation, and childbirth in ways that express dominant cultural notions of motherhood. The "Code" has long roots in the way that patriarchy has constructed women as mothers and as wombs. What is new is that increasingly these subordinating social norms are being institutionalized as legal duties. The result is the regulation of pregnant women.

I use "Code of Perfect Pregnancy" not only to describe the subtext of recent cases and statutes that there "ought to be a law" to control the behavior of pregnant women, and not only to invoke the more apparently normative, historically-based social code of good motherhood, but also to suggest other meanings of the word "Code." "Code" can refer to a restricted, controlled form of communication, one used to limit access to power to the few who hold the key.<sup>1</sup> Because the Code defines motherhood, it excludes only women.

Further, the Code operates by institutionalizing the dilemma of disempowerment. Under the Code, women bear the responsibility of "motherhood," but are not deemed entitled to the authority to define it.<sup>2</sup> The Code is double-edged. It operates by distinguishing between good mothers and bad mothers, incorporating some women into the subordinating ideology while subtracting from their power to claim alternative norms by making them moral exemplars to other women.

According to other fronts of patriarchy, motherhood is color-coded, class-coded, and culture-coded.<sup>3</sup> Women of color, those who live in poverty, and those made outsiders by virtue of cultural or religious practices are stigmatized by the dominant society and are never presumed good mothers, as are white middle- and upper-class women. In addition, even while outsider women are subject to the white-middle-class-good-mother standard, direct and indirect state actions expressing patriarchal norms deprive these women of the material, political, and social resources to conform to the Code. The Code says that these women do not and cannot have the key to opening the door of "good motherhood" or defining pregnancy in other terms.

A "Code" word is also a masked word, a word that has another function. In the past few years "fetal protection policy," "forced cesarean," "court-ordered hospital detention," "fetal abuse," and "fetal personhood" have become familiar terms. They are part of the new vocabulary being formed by

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<sup>1</sup> See PATRICIA J. WILLIAMS, *THE ALCHEMY OF RACE AND RIGHTS* 12-14, 147-65 (1991).

<sup>2</sup> See MARGARET ATWOOD, *THE HANDMAID'S TALE* 79 (1985) (describing a cautionary tale of a future totalitarian society in which "[t]here are only women who are fruitful and women who are barren, that's the law").

<sup>3</sup> This Article does not provide a full analysis of the ideology of motherhood. In particular, it only suggests the complex race-based description of motherhood that needs revealing. That project is beyond the scope of this Article.

the Code of Perfect Pregnancy. Jennifer Johnson, Kimberly Hardy, Pamela Rae Stewart, Angela Carder, Jessie Mae Jefferson, Ayesha Madyun, and Brenda Vaughn have become familiar names. These are some of the women deemed punishable at law by the Code. Certain phrases have also become familiar: "A child has the right to be born sound and healthy"; "Eleven percent of the babies born in hospitals test positive for drugs. There is a serious problem that can be addressed by punishing women who use drugs during pregnancy"; and "There must be something wrong with a mother who would not submit to surgery in order to insure the health of her child." These stories of the Code tell of an inevitable maternal-fetal conflict, of the sacrifice and submission of good mothers, and the selfishness and willfulness of bad mothers. More specifically, the Code speaks of protecting fetal interests from bad mothers. Yet the stories say little or nothing about the lack of access to prenatal care for poor women, or the dearth of addiction treatment for pregnant women, or the high miscarriage rate among imprisoned women, or the very conservative nature of the male-dominated mainstream obstetrical practice, or the religious and cultural integrity of women whose medical decisions differ from the doctor's, or the physical and emotional impact of pregnancy on women who feel their powerlessness.<sup>4</sup> The Code inserts the qualifier "but . . . in order to protect the fetus" after any mention of these facts. Within the Code, "but" has the job of denying social reality. Denying social reality makes it possible to escape the necessity of explaining how the subordination of women protects fetal interests and why less restrictive alternatives need not be used.

Because social reality is patriarchally constructed, patriarchal assumptions about gender, race, class, and culture implicitly shape the stories. Those assumptions are the social facts not put into words but present in the Code. The effect of the Code then is to direct the power of the state at women along race, class, and culture lines in the name of "protecting fetal interests." The resulting narrow standard for good motherhood has an effect beyond that of taking from women the authority to construct pregnancy and motherhood for themselves; it also eliminates the possibility of difference.

In this Article, I try to reveal the denial of social reality and the failure of explanation, and to show that the concept of "fetal interests" serves not to protect fetuses, but to enforce subordination. Accordingly, in Part II, I begin the process of challenging the stories of the Code by locating their roots largely in the historically-based, socially constructed ideology of motherhood,<sup>5</sup> in its late nineteenth and early twentieth century form. In Part III, I describe the developing regulatory scheme in terms of the ideology of motherhood in its

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<sup>4</sup> See RITA TOWNSEND & ANN PERKINS, *BITTER FRUIT: WOMEN'S EXPERIENCES OF UNPLANNED PREGNANCY, ABORTION, & ADOPTION* (1992) (containing interviews, poems, and visual art expressing the personal experience not recognized in law).

<sup>5</sup> See *infra* notes 6-7.

current form. In doing so, I take heed of the particular effects of the Code—it devalues women of color, poor women, and culturally stigmatized women as mothers. I also follow the call of others to challenge the ways in which normative theories are formed and expressed,<sup>6</sup> to locate and thus dislocate the floors and ceilings of the stories that require regulation of women as childbearers and that devalue motherhood along patriarchal lines. In Part IV, I explain that the Code of Perfect Pregnancy is the result of three particular manifestations of the dominant, authoritarian culture—the ideology of motherhood, the practice of defaulting to science, and the interventionist mindset of law. And in Part V, I elaborate upon the broad effects of a universal, decontextualized standard of good motherhood.

## II. THE IDEOLOGY OF MOTHERHOOD DURING THE LATE NINETEENTH AND EARLY TWENTIETH CENTURIES

The ideology of motherhood<sup>7</sup> has a very particular and complex form, drawn along patriarchal lines of race, class, and culture. In that sense the

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<sup>6</sup> See bell hooks, *Feminism: A Transformational Politic*, in THEORETICAL PERSPECTIVES ON SEXUAL DIFFERENCE 185, 186 (Deborah L. Rhode ed., 1990) (“Emphasizing paradigms of domination that call attention to woman’s capacity to dominate is one way to deconstruct and challenge the simplistic notion that man is the enemy, woman the victim; the notion that men have always been the oppressors. Such thinking enables us to examine our role as women in the perpetuation and maintenance of systems of domination.”); CATHARINE A. MACKINNON, TOWARD A FEMINIST THEORY OF THE STATE 244 (1989) (“The first step is to claim women’s concrete reality . . . . The next step is to recognize that male forms of power over women are affirmatively embodied as individual rights in law.”); Richard Delgado, *Storytelling for Oppositionists and Others: A Plea for Narrative*, 87 MICH. L. REV. 2411, 2413–14 (1989) (“Ideology—the received wisdom—makes current social arrangements seem fair and natural . . . . The cure is storytelling. . . .”); Mari Matsuda, *Looking to the Bottom: Critical Legal Studies and Reparations*, 22 HARV. C.R.-C.L. L. REV. 323, 324 (1987) (“Looking to the bottom—adopting the perspective of those who have seen and felt the falsity of the liberal promise—can assist critical legal scholars in the task of fathoming the phenomenology of law and defining the elements of justice.”); Patricia Williams, *Fetal Fictions: An Exploration of Property Archetypes in Racial and Gendered Contexts*, 42 FLA. L. REV. 81, 89 (1990) (“This commercialization of the fetus, this reduction of poor people of color to an owned relation to their body parts, this dispossession of the self through alienation therefrom can be tracked in other fetal rights and fetal abuse cases as well.”).

<sup>7</sup> I use the term “ideology” loosely. At the least, “ideology” refers to what Richard Delgado calls “the received wisdom.” It is an attempt to explain and justify the social reality. Delgado, *supra* note 6, at 2415. Or, as Clifford Geertz stated, “Whatever else ideologies may be—projections of unacknowledged fears, disguises for ulterior motives, phatic expressions of group solidarity—they are, most distinctively, maps of problematic social reality and matrices for the creation of collective conscience.” CLIFFORD GEERTZ,

ideology of motherhood may be as old as patriarchy. But in this section I focus on the late nineteenth and early twentieth centuries version of the ideology. I do so for two reasons. First, the post-civil war, industrial-age lines of patriarchy were clarified during that period.<sup>8</sup> Second, the legal mechanisms of control being enforced against women today echo those used at the turn of the century. In addition, as I discuss in Parts III and IV, medical science, and medical obstetrics in particular, came into being at that time as a source of authority and privileged knowledge in society.

The ideology of that period distinguished between privileged motherhood and devalued motherhood. Motherhood within the world of privilege—the white, middle and upper classes—was where the “Good Mothers,” those who held a sacred social trust, lived. In this section, I explore the notion of social duty described by the ideology. This older understanding of the social role of motherhood informs today’s version of the ideology. Although I spend less time on devalued motherhood, it was certainly not less significant. The important development during this period, for purposes of this Article, was the emergence of the white middle class as a normative force that dominated by casting all others in a negative light. The current version of the ideology, detailed in Part III, clearly extends the negative and truncated aspects of the motherhood construct.

### A. *Privileged Motherhood*

The Good Mother ideology begins on an essentialist note. It goes something like this. By biology, women are mothers. It is women who have the capacity to carry the conceptus, give birth to the baby, and nurse the child through infancy. This premise then supports the norm that women should have the primary responsibility for childrearing<sup>9</sup> and, concomitantly, that certain characteristics—nurturing, tenderness, compassion, and selflessness—are

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THE INTERPRETATION OF CULTURES 220 (1973). See also LINDA GORDON, WOMAN’S BODY, WOMAN’S RIGHT: A SOCIAL HISTORY OF BIRTH CONTROL IN AMERICA 10–11 (1976) (describing the “ideology” of motherhood, a phrase I adopt, which “made the biological processes of motherhood symbolic . . .”); CATHARINE MACKINNON, FEMINISM UNMODIFIED 8–10 (1987) (explaining gender as a social construct).

<sup>8</sup> See ANITA LEVY, OTHER WOMEN: THE WRITING OF CLASS, RACE, AND GENDER, 1832–98 (1991) (making a similar point with regard to late nineteenth century England).

<sup>9</sup> For an early critique of this role assignment, see Leta S. Hollingworth, *Social Devices for Impelling Women to Bear Children*, 22 AM. J. SOC. 19, 19–20 (1916–17) (“An exceedingly important and interesting phase of social control [is], namely, the control by those in social power over those individuals who alone can bring forth the human young, and thus perpetuate society . . . there has been a consistent social effort to establish as a norm the woman whose vocational proclivities are completely and “naturally” satisfied by child-bearing and child-rearing, with the related domestic duties.”).

natural to good mothers.<sup>10</sup> Further, the female reproductive system signifies that women are naturally suited to the role of producing a sound, healthy next generation by giving birth, milk, and moral guidance.

During the late nineteenth and early twentieth centuries it became particularly clear that the ideology defined motherhood in ways that make women buffers against social disorder. During the Victorian and early industrial periods the world became increasingly divided between the private and public spheres.<sup>11</sup> The private sphere was where virtue, morality, and tradition were founded. White middle- and upper-class women were confined to the private sphere and to the duty of maintaining virtue, morality, and tradition largely by inhabiting the "good mother" role.<sup>12</sup> More specifically, motherhood, as an institution, had the charge of transmitting social rules. Good mothers were responsible for conceiving, giving birth to, and raising children who would grow up to contribute to the social order and not detract from it.<sup>13</sup> Motherhood as a calling was fulfilled by individuals who were noble,<sup>14</sup> benign,<sup>15</sup> and self-sacrificing.<sup>16</sup>

Social problems, then, could be explained as a failure in the private sphere—the failure to sustain motherhood as an institution, and the failure of individual women to meet the standards of the calling. As a result, fear of social disorder has often been expressed by regulating women as mothers.<sup>17</sup>

<sup>10</sup> See GORDON, *supra* note 7, at 10–11.

<sup>11</sup> Ellen DuBois, *The Radicalism of the Woman Suffrage Movement: Notes Toward the Reconstruction of Nineteenth-Century Feminism*, in WOMEN, THE LAW AND THE CONSTITUTION 266, 266–69 (Kermit L. Hall ed., 1987); Nadine Taub & Elizabeth Schneider, *Perspectives on Women's Subordination and the Role of Law*, in THE POLITICS OF LAW 118–24 (D. Kairys ed., 1982).

<sup>12</sup> The good mother role and the ideology of motherhood were closely linked to the ideal of true womanhood that prevailed at that time.

<sup>13</sup> It was woman's duty to give "bias to the brain cells and soul impulses of ante-natal and post-natal infantile life," and to transmit to their children "fine ennobling sentiments, the solid truths of social relations, and the sterling principles of rightness, honor, honesty, and fraternal love." JOHN S. HALLER & ROBIN M. HALLER, THE PHYSICIAN AND SEXUALITY IN VICTORIAN AMERICA 80 (1974).

<sup>14</sup> But see BARBARA KATZ ROTHMAN, RECREATING MOTHERHOOD, IDEOLOGY AND TECHNOLOGY IN A PATRIARCHAL SOCIETY 43–50 (1989) (discussing how the woman's role in reproduction is first narrowly defined, and then devalued).

<sup>15</sup> *Bradwell v. Illinois*, 83 U.S. (16 Wall.) 130, 141 (1872).

<sup>16</sup> See GORDON, *supra* note 7, at 128–29; Hollingworth, *supra* note 9, at 21. For an interesting account of how these traits were both defined and commercialized as Mother's Day, see Leigh Eric Schmidt, *The Commercialization of the Calendar: American Holidays and the Culture of Consumption, 1870–1930*, J. AM. HIST. 887, 900–13 (Dec. 1991).

<sup>17</sup> See Hollingworth, *supra* note 9, at 21. Concern for maintaining population size has resulted in a variety of social controls to encourage childbearing. The means of social

That is, society responds to problems in ways that elaborate upon the ideology of motherhood. One traditional way of regulating women is fairly straightforward—by promulgating laws that restrict women to the private sphere roles of mother and wife.

In *Bradwell v. Illinois*,<sup>18</sup> the Illinois Supreme Court denied Myra Bradwell's application for a license to practice law because she was a woman. "That God designed the sexes to occupy different spheres of action, and that it belonged to men to make, apply, and execute the laws, was regarded as an almost axiomatic truth."<sup>19</sup> The idea that women could participate in the making and administering of laws was dismissed "rather as abstract speculation than as an actual basis for action."<sup>20</sup> In Justice Bradley's now infamous concurring opinion,<sup>21</sup> he supported the court's judgment by referring to the private sphere/public sphere distinction as fact.<sup>22</sup> The state, he asserted, can restrict women to the private sphere by declaring them unsuited for responsibilities in the public. Justice Bradley's opinion not only makes express the idea that the state could restrict women to the roles of wife and mother, but asserts that the state should do so for the good of society:

[T]he civil law, as well as nature herself, has always recognized a wide difference in the respective spheres and destinies of man and woman. . . . The

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control described and critiqued by Hollingworth include personal ideals, law, belief, education, art, and illusion.

<sup>18</sup> 83 U.S. (16 Wall.) 130 (1872).

<sup>19</sup> *Id.* at 132.

<sup>20</sup> *Id.* In affirming the Illinois Supreme Court's decision to exclude Myra Bradwell from the bar, United States Supreme Court Justice Miller relied on the argument that the right to be admitted to the state bar is not protected by the Privileges and Immunities Clause. "This right in no sense depends on citizenship in the United States." *Id.* at 139. The lower court decided that excluding Myra Bradwell from the practice of law accorded with legislative intent; however, it raised the broader question of "[w]hether, in the existing social relations between men and women, it would promote the proper administration of justice, and the general well-being of society, to permit women to engage in the trial of cases at the bar." *Id.* at 132. It is noteworthy that while Justice Miller used feminine pronouns in the opinion, in no other way did he acknowledge gender as an issue.

<sup>21</sup> For a critical discussion of the Bradley opinion, see Taub & Schneider, *supra* note 11, at 125-27; D. Kelly Weisberg, *Barred from the Bar: Women and Legal Education in the United States, 1870-1890*, in 2 WOMEN AND THE LAW: A SOCIAL HISTORICAL PERSPECTIVE 231, 238 (D. Kelly Weisberg ed., 1982); Joan Hoff Wilson, *The Legal Status of Women in the Late Nineteenth and Early Twentieth Centuries*, in WOMEN, THE LAW AND THE CONSTITUTION 357, 361-65 (Kermit L. Hall ed., 1987).

<sup>22</sup> This is the type of social fact that Professor Faigman refers to in his discussion of *Muller v. Oregon*, 208 U.S. 412 (1908). See David L. Faigman, "Normative Constitutional Fact-Finding": Exploring the Empirical Component of Constitutional Interpretation, 139 U. PA. L. REV. 541 (1991). Justice Bradley's view of the nature of society guides his finding that the Illinois Bar could exclude Myra Bradwell solely because of her gender.



constitution of the family organization, which is founded in the divine ordinance, as well as in the nature of things, indicates the domestic sphere as that which properly belongs to the domain and functions of womanhood. . . . The paramount destiny and mission of woman are to fulfill the noble and benign offices of wife and mother.<sup>23</sup>

The family is important to society. Women, as wives and mothers, are key to maintaining the “family institution.” Because society has an interest in women as wives and mothers, women can be regulated as such.<sup>24</sup> So the syllogism goes.<sup>25</sup>

The United States Supreme Court restated this syllogism in *Muller v. Oregon*.<sup>26</sup> The Court upheld state restrictions on working hours for women, while striking down similar restrictions for men.<sup>27</sup>

Even though all restrictions on political, personal and contractual rights were taken away, . . . it would still be true that she is so constituted that she will rest upon and look to them for protection; that her physical structure and a proper discharge of her maternal functions—having in view not merely her own health, but the well-being of the race—justify legislation to protect her . . . . The limitations . . . are not imposed solely for her benefit, but also largely for the benefit of all.<sup>28</sup>

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<sup>23</sup> *Bradwell*, 83 U.S. (16 Wall.) at 141.

<sup>24</sup> See *In re Goodell*, 39 Wis. 232 (1875). Lavinia Goodell sought admission to the Wisconsin Bar under a statute requiring applicants to meet certain age, residency, and character requirements. Although the court conceded that Goodell met the statutory requirements, it concluded that the statute applied only to males, and refused to apply traditional rules of statutory construction in order to bring women within the scope of the statute.

We cannot but think the common law wise in excluding women from the profession of law . . . . The law of nature destines and qualifies the female sex for the bearing and nurture of the children of our race and for the custody of the homes of the world and their maintenance in love and honor. And all life-long callings of women, inconsistent with these radical and sacred duties of their sex, as is the profession of the law, are departures from the order of nature; and when voluntary, treason against it.

*Id.* at 244–45.

<sup>25</sup> The current version of the motherhood ideology also uses law to regulate pregnant women by defining them as mothers of society.

<sup>26</sup> 208 U.S. 412 (1908).

<sup>27</sup> See *Lochner v. New York*, 198 U.S. 45 (1905) (invalidating maximum hour legislation for bakers as a violation of the liberty of contract).

<sup>28</sup> *Muller*, 208 U.S. at 422.

The Court relied on two physical distinctions—lack of strength relative to man and the ability to give birth. As a matter of ideology, these biological distinctions signify woman's cultural function—producing and nurturing children in order to ensure the future well-being of the race.<sup>29</sup> As a matter of cultural practice reflected in law, the economic freedom of women can be restricted to protect the unborn child and society.<sup>30</sup>

Further, the footnotes to the *Muller* opinion and the original "Brandeis brief"<sup>31</sup> offered four justifications for restricting the workday for women: "(a) the physical weakness and difference of women relative to men, (b) her maternal functions, (c) the rearing and education of children, [and] (d) the maintenance of the home . . . . [Each justification is] so important and so far reaching that the need for such reduction need hardly be discussed."<sup>32</sup> The first reason listed arguably protects the woman's interests.<sup>33</sup> But the other three reasons speak of the ideology of motherhood and of protecting the interests of others, not those of the woman.<sup>34</sup> The message is clear: Although women are responsible for the next generation, they are not entitled to make certain choices, to take certain risks that men can take, because women lack the ability to make decisions necessary for protecting the next generation. Hence, even though women bear the broad responsibility of motherhood, they are not

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<sup>29</sup> See NANCY REEVES, WOMANKIND: BEYOND STEREOTYPES 90-91 (2d ed., 1982) (citing *Muller* and *Bradwell* as illustrations of the "unquestioned norm" that woman's biological capacity to bear children and man's superior physical strength indicate their place in the cultural order); Wilson, *supra* note 21, at 364 (characterizing the *Muller* decision as "the worst of all possible legal arguments in terms of equality of treatment of women" because "the Court concentrated on her procreative functions and those of all American working women").

<sup>30</sup> For a feminist critique of this point, see Nancy Erickson, *Historical Background of "Protective" Labor Legislation: Muller v. Oregon*, in 2 WOMEN AND THE LAW 155, 157 (D. Kelly Weisberg ed., 1982) (The justification "is even more objectionable because it treats women as objects: as means rather than ends."); Mary E. Becker, *From Muller v. Oregon to Fetal Vulnerability Policies*, 53 U. CHI. L. REV. 1219, 1224-25 (1986) (listing several troubling aspects of the argument in the context of a larger evaluation of sex-specific employer protection policies). Among the problems listed are, "[f]irst, . . . [w]omen were seen as uniformly dependent on men, and women's financial contributions to their families as less important than their biologic and domestic contributions. Second, women were not regarded as individuals . . . . Instead, all women were seen only in terms of the biologic and domestic responsibilities associated with motherhood." *Id.* Until recently, employers used "fetal protection policies" to exclude women from jobs. See *infra* notes 412-23 and accompanying text.

<sup>31</sup> Erickson, *supra* note 30, at 159, nn.35-38.

<sup>32</sup> *Muller*, 208 U.S. at 420, n.1.

<sup>33</sup> In 1973, the Court condemned this type of "romantic paternalism." See *Frontiero v. Richardson*, 411 U.S. 677, 684 (1973).

<sup>34</sup> Erickson, *supra* note 30, at 159.

entitled to the authority to define it.<sup>35</sup> Recent cases in which judges side with physicians to override a pregnant woman's medical treatment decision and cases that more generally punish women for prenatal behavior without acknowledging their social reality effect this dilemma of disempowerment.

A less direct way of maintaining social order is to impose laws that treat women who do not fit the norms as deviants, as the cause of disorder. In the late nineteenth and early twentieth centuries many church and political figures feared that industrialization was destroying the established order.<sup>36</sup> Lecturers and editorial writers preached that the power of the family as an instrument of control was waning, resulting in a future of moral and physical degeneracy.<sup>37</sup> During the late nineteenth century this fear expressed itself as the Social Purity Movement.<sup>38</sup> Supporters crusaded against prostitution, alcohol, and pornography. The movement united a wide variety of interests by highlighting the idea that reinstating the family as the primary vehicle of social control would save America,<sup>39</sup> and that preserving true womanhood and good motherhood<sup>40</sup> would achieve that rescue.

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<sup>35</sup> The story of Fanny Kemble, told by Eleanor Boatwright, illustrates how this part of the ideology affected women in marriage and upon divorce. Fanny Kemble was a successful English actress who married a southern plantation owner, Pierce Mease Butler. She held, in her husband's words, "peculiar views . . . that marriage should be a companionship on equal terms—partnership, in which if both partners agreed all is well—but at no time has one partner a right to control the other." Mr. Butler, on the other hand, believed in "the customary and pledged acquiescence of a wife to marital control—nothing more." Pierce M. Butler, *Mr. Butler's Statement, Originally prepared with the aid of his Professional Council* 9–10 (Philadelphia, 1850) (quoted in Eleanor Boatright, *The Political and Civil Status of Women in Georgia 1783–1860*, 25 GA. HIST. Q. 301, 315 (Dec. 1941)). At the child custody determination upon divorce, she was confronted with the common law's expression of her husband's views, that "a mother as such is entitled to no power but only to reverence and respect." *Id.* at 315 (quoting 1 WILLIAM BLACKSTONE, COMMENTARIES § 454).

<sup>36</sup> DuBois, *supra* note 11, at 266–67.

<sup>37</sup> The demands placed on the family as a socializing institution increased during this period. "On the one hand, the family remained, at least throughout the nineteenth and first half of the twentieth centuries, the primary means of socialization of children into adults with personalities appropriate to the demands of industrial capitalism . . . . On the other hand, the family was called upon to absorb the heavy strains that the economy placed upon individuals." GORDON, *supra* note 7, at 20. The belief that acquired characteristics were hereditary intensified "the cult of motherhood." *Id.*

<sup>38</sup> See GORDON, *supra* note 7, at 116–20; Anita L. Morse, *Pandora's Box: An Essay Review of American Law and Literature on Prostitution*, 4 WIS. WOMEN'S L.J. 21, 38–39 (1988).

<sup>39</sup> See GORDON, *supra* note 7, at 116–35; Morse, *supra* note 38, at 23. During the 1992 presidential election campaign, "family values" became a focal point for defining political views. It raised debate about the meaning and content of "family values," and which candidate had the best "family values." At least in part, the debate among the general

As an example, the Social Purity Movement's crusade against prostitution expressed in various ways the idea that, for the good of society, women must remain in their private sphere roles of wife and mother. Social mores cast prostitutes as "fallen women," weak women who in betraying the norms had placed social order in jeopardy. Prostitutes contributed to social disorder in a variety of ways, including purportedly spreading syphilis.<sup>41</sup> Because prostitutes were presumed to be both morally and intellectually inferior, and because both types of inferiority were believed hereditary, prostitutes tainted the race by having substandard children.<sup>42</sup> Furthermore, prostitution contributed to the

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population indicated that many perceive a strong correlation between the strength of the institution of family and control of societal problems. See Lance Morrow, *Family Values*, TIME, Aug. 8, 1992, at 23-27. Cf. Catherine McClay, *The Way We Were*, CALIFORNIA MONTHLY, Feb. 1992, at 10, 12 (reviewing ARLENE SKOLNICK, *EMBATTLED PARADISE* (1991) and citing Professor Skolnick's point that family change is the result of, not the cause of, social change).

<sup>40</sup> Morse, *supra* note 38, at 48.

<sup>41</sup> Kay Ann Holmes, *Reflections by Gaslight: Prostitution in Another Age*, in WOMEN, THE LAW AND THE CONSTITUTION 367 (Kermit L. Hall ed., 1987). Venereal disease statutes also contained the assumption that prostitutes spread syphilis. New York's Venereal Disease Act of 1918 is excerpted below:

Every citizen arrested for vagrancy as defined under subdivision 3 or 4 section 887 of the code of criminal procedure (prostitution clause) of the tenement house law or under any statute or ordinance for any offense of the nature specified in subdivision 4 of section 887 of the code of criminal procedure, or arrested and charged with a violation of section 1146 of the penal law or 1148 of the penal law or any person arrested for living in a disorderly house or house of prostitution, shall be reported within 24 hours by the court or magistrate before whom such person is arraigned to the board of health or health officer and shall be examined in accordance with the provisions of the proceeding section. For the purpose of the examination such person may be detained until the results of such an examination are known. No such person if convicted shall be released from the jurisdiction of such court or magistrate until the person so convicted has been examined as provided for in the proceeding section.

*Id.* at 382 (citation omitted).

<sup>42</sup> GORDON, *supra* note 7, at 121-22; Holmes, *supra* note 41, at 374-76. There were calls for the sterilization of prostitutes based on the heredity argument. At the 1911 annual meeting of an anti-syphilis, anti-prostitution organization, The American Society of Sanitary and Moral Prophylaxis, Dr. John N. Hurty, Secretary of the Indiana State Board of Health and State Health Commissioner, cast sterilization of the morally and physically degenerate as necessary for the future of the nation.

We are filling our almshouses, hospitals, jails, penitentiaries and homes for the morally and physically unfortunate by our refusal to meet the social question,

corruption of minors.<sup>43</sup>

Reformers believed that criminalizing prostitution would protect children and families from harm. For example, social crusaders declared syphilis an epidemic by 1890. According to reports, seventy percent of all female patients in New York hospitals were married women infected by their husbands and ninety percent of men with syphilis were infected by prostitutes.<sup>44</sup> Crusaders also blamed syphilis for all miscarriages and all cases of blindness at birth.<sup>45</sup> Because prostitutes were the purported source of syphilis,<sup>46</sup> restricting prostitution would eliminate the effects of syphilis on innocent, pure women and children.<sup>47</sup> According to Darwinian notions it would also prevent deterioration of the gene pool and reduce the likelihood of corrupting minors.

More importantly, crusaders held that prostitutes created social disorder because their existence contradicted the ideal of female asexuality and passivity.<sup>48</sup> Prostitutes acted outside the home in an outlaw marketplace and, most significantly, they were not “virtuous” according to the strict moral standards of the time. Because virtuous women, in their role as universal nourisher,<sup>49</sup> bore the responsibility of maintaining and transmitting family

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the sex question, the prevention of the procreation of degenerates in an honest, sensible, pure-minded manner. . . .

Would it not be worth something to this nation in dollars and cents to raise men and women who are physically sound? Does not the future and the perpetuity of our nation, politically and commercially depend upon a generation that is clean limbed and clear-headed, possessed of brain, brawn, nerve, and are free from taint and weakness?

John H. Hurty, *The Sterilization of Criminals and Defectives*, 3 SOC. DISEASES 1, 17 (1912).

<sup>43</sup> Hurdy, *supra* note 42, at 38–44. Many believed that a widespread White Slave Trade existed which depended upon a constant supply of young girls who had been kidnapped and seduced. So, eliminating prostitution would protect young girls. It would protect boys from the corrupting influences of sex. By law, a boy “found of his . . . own free will and knowledge in a house of prostitution or assignation of ill fame . . . may be deemed a wayward minor.” *Id.* at 38–39. *See also* CYRUS WILLOUGHBY WATERMAN, PROSTITUTION AND ITS REPRESSION IN NEW YORK CITY, 1900–1931, *reprinted in* HISTORY, ECONOMICS, AND PUBLIC LAW 38–39 (Faculty of Political Science of Columbia University eds., 1968) (1932) (quoting New York’s Wayward Minors Act).

<sup>44</sup> Holmes, *supra* note 41, at 370.

<sup>45</sup> *Id.*

<sup>46</sup> *Id.* at 370–71.

<sup>47</sup> *Id.* at 371.

<sup>48</sup> Morse, *supra* note 38, at 24; GORDON, *supra* note 7, at 118–19. Note that in reality most prostitutes were not autonomous with the capacity to negotiate the commercial sphere on their own behalf. Their “bad” behavior was mediated through the power of men directly or through female overseers or “madams” whom men allowed to maintain control over these “bad” women.

<sup>49</sup> *See* GORDON, *supra* note 7, at 10 (using the term “universal nourisher”).

values, and because family values were the source of social order, it was the non-virtuous woman who was most directly responsible for disorder. The crusade against prostitution thus reinforced the idea that when women failed to participate in the ideology of motherhood, physical and moral evils proliferated.<sup>50</sup>

Condemning prostitutes as “bad” women reinforced the idea that the role of women in upholding virtue for the sake of others is a natural one. Women who failed to accept that role were abnormal and in need of control.<sup>51</sup> This conclusion was reached by a complex logic. There were at least two views as to why women became prostitutes. First, many asserted that women became prostitutes by choice.<sup>52</sup> Second, others believed that women who became prostitutes did so because of a sudden misfortune, poverty, or other unfortunate circumstances.<sup>53</sup> Under either view, these women were weak and in need of control for the sake of the innocent women and children, the institution of family, and the future of the nation.<sup>54</sup>

The secondary moral justification for regulating prostitution was the same one offered for regulating working hours for women—the protection of children.<sup>55</sup> Regulating prostitution would not only protect children from syphilis, genetic degeneracy, and corruption, it would also tell women to stay at home and be good mothers, as the emerging science of early childhood development dictated. It strengthened the ideology of motherhood by restating the thesis that today’s well-nurtured children would lead us into a moral tomorrow.<sup>56</sup> The crusade against prostitution presented the syllogism described

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<sup>50</sup> Today, the “problem” of drug- and alcohol-addicted pregnant women is characterized similarly. The women are assumed to have control over their behavior, so they are blamed for willfully spreading social disorder and giving birth to addicted infants. *See infra* notes 316–42 and accompanying text.

<sup>51</sup> Morse, *supra* note 38, at 24–25. For a contemporary (1916–1917) explication of the forces used “to keep [women] childbearers and child-rearers,” see Hollingworth, *supra* note 9.

<sup>52</sup> *See, e.g.*, Holmes, *supra* note 41, at 372 (citing Report by Committee of 15, formed in 1910, to study the “problem” of prostitution). “Women are attracted rather than forced into prostitution—the earnings, the rich attire, and more luxurious mode of life is a strong attraction.” *Id.*

<sup>53</sup> *See, e.g.*, J. ADDAMS, *NEW CONSCIENCE AND AN ANCIENT EVIL* (1912) (Arno Press ed., 1972); W. SANGER, *THE HISTORY OF PROSTITUTION: ITS EXTENT, CAUSES AND EFFECTS THROUGHOUT THE WORLD* 488–89 (1897) (reprint 1976).

<sup>54</sup> Morse, *supra* note 38, at 25 (noting that laws against prostitution included prosecuting the male customers, but male customers were “very seldom arrested because male purchase of sex was acceptable legal and social behavior”). The rhetoric of control for the sake of others is a prevailing theme of the Code of Perfect Pregnancy.

<sup>55</sup> *See, e.g.*, ELIZABETH BLACKWELL, *ESSAYS IN MEDICAL SOCIOLOGY* 119–20, 164–74 (1902).

<sup>56</sup> Morse, *supra* note 38, at 33–34.

by *Bradwell* and *Muller*. The normal role for a woman is that of wife and mother. The woman who forsakes these roles not only harms herself, but also fosters disorder on a society-wide basis. Women, therefore, can be regulated for the purpose of preventing these harms.

Even though the rhetoric from earlier times may now seem exaggerated<sup>57</sup> and women are no longer entirely restricted to the private sphere,<sup>58</sup> the Code contains haunting parallels.<sup>59</sup> The cultural practice of regulating women as mothers and making them responsible for the next generation, as a way of expressing fears of social disorder, still occurs. That is, the part of the motherhood ideology that characterizes women as naturally virtuous, tender, and compassionate is less prominent today.<sup>60</sup> The assumption that women are more naturally suited to the role of childraising than men is also less strong. But, the idea of a "normal" mother as nurturing and self-sacrificing remains deeply entrenched in today's society. The law still reflects the ideology by restraining women to be mothers and by penalizing women who are not "good" mothers.

### B. Devalued Motherhood

Patriarchy devalued motherhood in at least three ways during the late nineteenth and early twentieth centuries. First, it operated on a class basis by presuming that the "Good Mother" model, derived from middle- and upper-class values and experiences, should apply regardless of class. Second, it used negative stereotypes of recent immigrants to devalue motherhood on ethnic lines. Third, it offered race-based mother models for women of color that truncated their roles or that described women of color as "natally dead."<sup>61</sup>

The three examples in subpart A rest on the public sphere/private sphere distinction. But that public/private construct described (and proscribed) the life

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<sup>57</sup> See generally LAWRENCE H. TRIBE, AMERICAN CONSTITUTIONAL LAW § 8-4, at 573, n.20 ("From a modern and less sexist perspective, the . . . concern with the proper role of women can be understood partly as an attempt to freeze women within the role of wives and mothers, and partly as reflecting the then-popular conception that the genetic composition of humanity would be adversely affected should women become too involved in the labor force."); Becker, *supra* note 30, at 1219; Faigman, *supra* note 22; Fran Olsen, *From False Paternalism to False Equality: Judicial Assaults on Feminist Community, Illinois 1869-1895*, 84 MICH. L. REV. 1518 (1986).

<sup>58</sup> Historically, the legal disabilities placed on women, in conjunction with the prevailing social norms, ensured that women remained confined to the private sphere. As these disabilities were removed and women entered the marketplace and became a significant voice in the community, they ceased to be defined solely as wives and mothers.

<sup>59</sup> See generally SUSAN FALUDI, BACKLASH (1992).

<sup>60</sup> But see CAROL GILLIGAN, IN A DIFFERENT VOICE (1982).

<sup>61</sup> TONI MORRISON, PLAYING IN THE DARK 21 (1992).

of middle- and upper-class women. Economic necessity generally mandated that poor women and women of color worked outside the home.<sup>62</sup> So these women were held to a Good Mother standard that had little to do with their economic reality. Not surprisingly, the use of state power described in *Bradwell*, *Muller* and by the Social Purity crusaders—disallowing access to public sphere power, imposing economic restrictions, and blaming and prosecuting “bad” women, all for social good—to enforce the ideology fell most heavily on non-privileged women. These women were least able to comply with expectations of round-the-clock caretaking, nurturing, and moral guidance. The denial of their economic reality put the focus on their personal traits. It also set economic standards for motherhood, thus commodifying it, making good mothering something one could buy.

The jingoistic response to the southern and eastern European immigrants who arrived from the 1880s made it clear that good motherhood was economically and educationally privileged, and that it had ethnic content as well.<sup>63</sup> Juvenile delinquency became a social and political issue during the early twentieth century.<sup>64</sup> Stereotypes assumed the inherent sexual immorality of immigrant women.<sup>65</sup> Courts blamed the mothers of these girls.<sup>66</sup> Thus, immigrant girls or daughters of immigrants were disproportionately punished for juvenile delinquency, and immigrant women were disproportionately blamed for the social problem. Negative ethnic stereotypes fed the crusade against prostitution as well.<sup>67</sup> One stereotype of the woman who became a prostitute depicted her as ethnic. Ethnicity was part of her immoral, socially destructive character.

The ideology also devalued motherhood on racial lines. It defined mothering roles for Black women in subordinated positions within white households. Black women could be nannies and wet nurses.<sup>68</sup> They were trusted with performing the physical tasks of motherhood, but not the moral duty of inculcating children with proper values. Thus, it was assumed that they should and could leave their own children at home in order to care for white

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<sup>62</sup> See Phyllis Marynick Palmer, *White Women/Black Women: The Dualism of Female Identity and Experience*, in FROM DIFFERENT SHORES: PERSPECTIVES ON RACE AND ETHNICITY IN AMERICA 167, 170–71 (Ronald Takaki ed., 1987).

<sup>63</sup> See Maxine S. Seller, *Beyond the Stereotype: A New Look at the Immigrant Woman*, in FROM DIFFERENT SHORES: PERSPECTIVES ON RACE AND ETHNICITY IN AMERICA 197 (Ronald Takaki ed., 1987).

<sup>64</sup> Stephen Schlossman & Stephanie Wallach, *The Crime of Precocious Sexuality: Female Juvenile Delinquency in the Progressive Era*, in UNITED STATES CONSTITUTIONAL AND LEGAL HISTORY 65, 68 (Kermit L. Hall ed., 1987).

<sup>65</sup> *Id.*

<sup>66</sup> *Id.* at 75.

<sup>67</sup> Holmes, *supra* note 41, at 83, 88.

<sup>68</sup> Palmer, *supra* note 62, at 167.



children. The children of Native American women were sent to boarding schools in large part so they could not learn from their mothers.<sup>69</sup> Because racial stereotypes described Black women and Native American women as more like animals than rational beings, it was said that they would not feel the pain of these racially and economically forced separations as “normal” women would. They were considered “natally dead.”<sup>70</sup> But at the same time they were blamed for failing to meet the Good Mother standard and hence for reproducing social problems.

The late nineteenth and early twentieth century version of the ideology forecasts the current regulation of pregnant women. It explains why women as mothers can be held responsible for social problems. It describes a Good Mother model that speaks from a particular class, race, and ethnic experience and then universalizes that model as a standard that should apply in disregard of other particular realities. And it devalues motherhood on race, class, and cultural lines.

### III. THE CURRENT IDEOLOGY: THE REGULATION OF PREGNANT WOMEN

In this section, I will discuss the aspect of the current version of the motherhood ideology that focuses on pregnant women. I will use certain historical comparisons to show four things. First, the ideology of motherhood is most clearly expressed in law with restrictions that speak to women’s biological capacity to conceive and bear children, not with laws confining women to the private sphere. However, while these laws and proposals most directly affect women’s reproductive liberty and the twin values of bodily integrity and decisional autonomy, they also proscribe our larger understanding of liberty, integrity, and autonomy. This effect in turn solidifies assumptions of subordination and prevents liberating ideology. Second, over the past century, these laws have begun to take the shape of an increasingly comprehensive regulatory scheme. There is not yet a Code *per se*. But there is a growing sense that there ought to be a Code. Third, the law is invading a set of choices not regulated before and it is doing so largely in the name of “fetal interests” and social good. These are the current code words for subordination. Finally, the ideology now defines good motherhood largely by negative example, and the devalued mother continues to be drawn on race, class, and culture lines.

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<sup>69</sup> EVELYN C. ADAMS, *AMERICAN INDIAN EDUCATION: GOVERNMENT SCHOOLS AND ECONOMIC PROGRESS* 54–58 (1971); *NATIVE AMERICAN TESTIMONY: A CHRONICLE OF INDIAN-WHITE RELATIONS FROM PROPHECY TO THE PRESENT, 1492–1992*, 213–24 (Peter Nabokov ed., 1991); *REPORT OF THE INDIAN COMMISSIONER, 1886*, XXIV IN U.S. OFFICE OF EDUCATION, *INDIAN EDUCATION AND CIVILIZATION*, 48th Cong., 2d Sess., S. Exec. Doc. No. 95 (1888).

<sup>70</sup> MORRISON, *supra* note 61.

Reproductive liberty can serve as the starting point for analysis. It is often described in terms of the procreative process: Conception, gestation, and childbirth.<sup>71</sup> Until recently, attempts to regulate the woman as childbearer have been aimed primarily at controlling choices surrounding conception. That is, regulations have taken the form of state laws that restrict a woman's ability to determine whether to conceive, how to conceive, and whether to terminate the pregnancy. These regulations elaborate upon the ideology of motherhood by stating preferences about who should and who should not become pregnant and hence become mothers.

In the past few years, however, state regulations have emphasized a different question: To what extent can the state restrain a woman during pregnancy? The regulation of pregnancy has been premised on a singular construct: the maternal-fetal conflict. This oppositional description of pregnancy frames the legal issue in either/or terms and suggests that there must be a winner and a loser. Hence, the legal issue becomes whether the state should protect maternal *or* fetal interests. The use of the construct of conflict to the exclusion of all other descriptions of pregnancy also precludes women from defining pregnancy and the choices surrounding it for themselves. And the ideology of motherhood invests certain "choices" with greater moral weight. This proscribes the social and political reality of choice. And it justifies legal intervention to prevent "bad" choices and punish "bad" mothers.

## A. *Control of Conception*

### 1. *Restrictions on Contraception*

In terms of biological processes, the first locus of control is the decision of whether or not to conceive.<sup>72</sup> Birth control by contraceptive is an ancient idea and practice.<sup>73</sup> Birth control as a political movement in the United States began

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<sup>71</sup> See John A. Robertson, *Procreative Liberty and the Control of Conception, Pregnancy, and Childbirth*, 69 VA. L. REV. 405 (1983).

<sup>72</sup> At least one commentator has suggested regulating women before conception. See *infra* notes 259-64 and accompanying text.

<sup>73</sup> Ancient and pre-industrial women invented and utilized numerous birth control methods. Although coitus interruptus, or male withdrawal, was the most common method, its success hinged on the skill of the male. Thus, in order to achieve reproductive control, it became necessary for women to create other devices. Herbal brews and potions were among the first contraceptives, but proved to be almost a complete failure. A far more effective method was the pessary, a technique dating back to 1850 B.C. A pessary was a vaginal suppository, or in some cases, a solid object, used to obstruct the path to the cervix, and was particularly effective when used in combination with some type of spermicidal substance. Douching, external manipulations of the uterus, and even rudimentary surgical

in the late nineteenth century.<sup>74</sup> For reasons largely tied to maintaining narrow roles for women, birth control was considered immoral. Since families were considered the primary mechanism for social control, society placed a premium, through the motherhood ideology, on large families.<sup>75</sup> To many, only large white families were desirable; the privileged, white middle and upper classes feared birth control would prove “racially devastating” because it would be used primarily by their own.<sup>76</sup> In addition, they associated birth control with prostitutes and female sexuality.<sup>77</sup> So birth control was believed to be anathema to social control.<sup>78</sup> By 1873, law contained the social

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sterilizations were other common methods of contraception in pre-industrial society. GORDON, *supra* note 7, at 40–46.

Although birth control has existed for centuries, it has always been socially regulated. *Id.* at 3. For example, coitus interruptus and the use of condoms were the most widely practiced methods of birth control in the nineteenth century. However, both practices were condemned by the medical profession, which recommended contraceptive techniques only when health reasons required that the woman avoid pregnancy. Although the medical profession was clearly aware of simple and effective contraceptives, it believed that dissemination of this information would encourage prostitution and cause a decrease in the number of marriages. HALLER & HALLER, *supra* note 13, at 114, 122–23 (1974).

Since even legal prohibitions could not stop the private practice of birth control, religious ideology became the dominant force in convincing couples that birth control was immoral. GORDON, *supra* note 7, at 5. Early Christianity viewed sex as inherently evil, and justified only for purposes of procreation. Thus, any methods employed to avoid procreation were condemned. Although Protestant church officials attempted to ignore the issue, the Catholic Church remained steadfast in its condemnation of prevention techniques. So deeply ingrained were these views, that by the nineteenth century, spreading information about birth control was not only immoral, but also illegal. *Id.* at 3–9.

<sup>74</sup> GORDON, *supra* note 7, at 3. The supporters of voluntary motherhood (suffragists, moral reformers, and free-love advocates) promoted birth control as a means of social reform. *Id.* at 95.

<sup>75</sup> GORDON, *supra* note 7, at 10. Many viewed birth control as a “rebellion of women against their primary social duty—motherhood.” *Id.* at 137.

<sup>76</sup> DANIEL KEVLES, *IN THE NAME OF EUGENICS: GENETICS AND THE USES OF HUMAN HEREDITY* 88 (1985). The term “race suicide” referred in part to the fear that “Yankee ‘stock,’ which displayed the lowest birth rates, would be overwhelmed, numerically and hence politically, by immigrants, nonwhites, and the poor.” *Id.* See also GORDON, *supra* note 7, at 137. President Theodore Roosevelt spoke of race suicide in 1903: “Among human beings, as among all other living creature[s], if the best specimens do not, and the poorer specimens do, propagate, the type [race] will go down.” BARBARA EHRENREICH & DEIRDRE ENGLISH, *FOR HER OWN GOOD: 150 YEARS OF THE EXPERTS’ ADVICE TO WOMEN* 135 (1979).

<sup>77</sup> GORDON, *supra* note 7, at 21–22.

<sup>78</sup> But see Hollingworth, *supra* note 9, at 21. In 1916, Hollingworth challenged “maternal instinct” as a myth used to encourage women to be childbearers. She also identified “public opinion, law, belief, social suggestion, education, custom, social religion, personal ideals, art, personality, enlightenment, illusion, and social valuation” as “devices

condemnation of birth control. Congress passed the Comstock Act, which prohibited distributing or advertising obscene material, including contraceptives.<sup>79</sup> The law banned access to both male and female contraceptives,<sup>80</sup> but its effect was to legislate a preference for pregnancy.

Statutes restricting access to contraceptives have been declared unconstitutional restraints on individual choice in the twentieth century.<sup>81</sup> So women could choose sexuality without motherhood. But recently, political opposition to abortion has been expressed by limiting or threatening to limit access to birth control methods, such as RU-486, the "weak" pill, and the IUD.<sup>82</sup> These statutes represent the expansion of traditional reproduction

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for impelling women to maintain a birth rate sufficient to insure enough increase in the population to offset the wastage of war and disease."

<sup>79</sup> Comstock Act, ch. 258, § 2, 17 Stat. 598 (1873), codified at 18 U.S.C. §§ 1461, 1462 (repealed 1971). The Comstock Law made it a misdemeanor to sell, lend, give away, exhibit, offer to sell, knowingly deposit in the mails, and import "any article whatever, for the prevention of conception." While the Comstock Act repealed the prohibition against transmittal of contraceptives, it prohibited the mailing of unsolicited birth control information or material unless sent to persons listed in the statute, such as physicians and nurses. Act of Jan. 8, 1971, Pub. L. No. 91-662, §§ 3, 4, 84 Stat. 1973.

<sup>80</sup> See HALLER & HALLER, *supra* note 13, at 114-15. Withdrawal, condoms, diaphragms, and vaginal douches were among the more popular types of contraception used during this period. *Id.*

<sup>81</sup> *Eisenstadt v. Baird*, 405 U.S. 438 (1972); *Griswold v. Connecticut*, 381 U.S. 479 (1965). "If under *Griswold* the distribution of contraceptives to married persons cannot be prohibited, a ban on the distribution [of contraceptives] to unmarried persons would be equally impermissible . . . . If the right to privacy means anything, it is the right of the individual, married or single, to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child." *Eisenstadt*, 405 U.S. at 453 (emphasis added).

<sup>82</sup> In *Webster v. Reproductive Health Services*, 492 U.S. 490 (1989), the Supreme Court upheld a Missouri abortion restriction. The plurality declined to address the validity of the statutory preamble that declared, "[t]he life of each human being begins at conception . . . ." MO. REV. STAT. §§ 1.205-1(1), (2), 1.205-2 (1986). However, five of the justices found that the provision "unconstitutionally burdens the use of contraceptive devices, such as the IUD and the 'morning after' pill. . . ." 492 U.S. at 541 n.1 (J. Blackmun, with whom J. Brennan, and J. Marshall join, concurring in part and dissenting in part, and with whom J. O'Connor on this point joins); 492 U.S. at 561-64 (J. Stevens, concurring in part and dissenting in part). See also *Benton v. Kessler*, 112 S. Ct. 2929 (1992) (denying Leona Benton's application to vacate the Court of Appeals stay of a preliminary injunction. The injunction would have compelled the Food and Drug Administration to return a single dosage of RU-486 that she imported from France in order to terminate her 7 week pregnancy.); Mindy J. Lees, Note, *I Want a New Drug: RU-486 and the Right to Choose*, 63 S. CAL. L. REV. 1113 (1990). On January 23, 1993, the anniversary of *Roe v. Wade*, President Clinton revoked prohibitions on the importation of RU-486 pending Food and Drug Administration approval. Karen Tumulty & Marlene Cmons, *Clinton Lifts Restrictions on Abortion*, L.A. TIMES, Jan. 23, 1993, at A1.

regulation. The access restrictions to birth control seem to state a preference at law for motherhood—the idea that a woman’s purpose is reproduction and childrearing. Criticisms of teenage pregnancy and single motherhood, aimed largely at women of color,<sup>83</sup> qualify that preference. When viewed in social context, then, the contraception restrictions state a preference for motherhood that is white, married, and probably middle class.

## 2. Restrictions on Abortion

Statutes restricting abortion are probably the most well-known form of reproduction regulation. Highly publicized and often volatile debates have taken place between pro-choice and pro-life forces over abortion statutes.<sup>84</sup> In some ways, these debates continue discussions that began when the abortion issue became part of the nineteenth century birth control movement. Anti-abortionists argued then, in part, that abortion violates “natural law.”<sup>85</sup> Early birth control supporters, like today’s supporters, articulated claims to reproductive control by casting the issue in terms of male privilege and male sexual domination.<sup>86</sup>

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<sup>83</sup> CONSTANCE WILLARD WILLIAMS, *BLACK TEENAGE MOTHERS: PREGNANCY AND CHILD REARING FROM THEIR PERSPECTIVE* 9 (1991); see also Daniel Patrick Moynihan, *The Negro Family: The Case for National Action*, OFFICE OF POLICY PLANNING AND RESEARCH, U.S. DEPARTMENT OF LABOR (1965) (characterizing Black families as woman-centered and linking that family structure to joblessness, illegitimacy, poverty, and other issues).

<sup>84</sup> See, e.g., Robin Toner, *Abortion Fight Goes On, State by State by State*, N.Y. TIMES, Jan. 21, 1991, at A18. More recently, Operation Rescue, the pro-life group founded by Randall Terry of Binghamton, New York, mounted a vigorous anti-abortion protest in Wichita, Kansas. The protest began July 15, 1991. Over two thousand protesters had been arrested by early August. Judge Kelly, whose orders kept the three area abortion clinics open, received death threats. By mid-August, both protester tactics and police responses began to escalate. One journal reported, “[f]or the first time Friday, children as young as 8 years old lay down in front of cars entering the clinic. And the marshals and police who arrested 99 protesters, including a 13-year-old, no longer let them shuffle: They were dragged or, in the teen’s case, carried.” Judy Lundstrom Thomas, *‘Summer of Mercy’ Rally Escalates; Abortion Tug-of-War Rends Wichita*, NEWSDAY, Aug. 11, 1991, at 17; see also *U.S. Judge in Abortion Case is Target of Death Threats*, N.Y. TIMES, Aug. 8, 1991, at A16.

<sup>85</sup> GORDON, *supra* note 7, at 35.

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Is it “proper,” “polite,” for men, real *he* men, to go to Washington to say, by penal law, fines and imprisonment, whether women may continue her natural right to wash, rinse, or wipe out her own vaginal opening—as well as legislate when she may blow her nose, dry her eyes, or nurse her babe . . . . Whatever she may have been pleased to receive, from man’s own, is his gift and her property. Women do not like rape, and have a right to resist its results . . . . To cut a child

Resulting state statutes restricted a woman's decision whether to terminate a pregnancy.<sup>87</sup> Before that, physicians were prohibited by common law from performing an abortion after "quickening."<sup>88</sup> Before it "quickened," the fetus was considered a potential for human life, but not a human being. The law did not interfere with the woman's abortion decision before that time.<sup>89</sup> With increased understanding of the gestational process, "viability" became the legal point at which state interests in protecting potential life outweighed those of the pregnant woman so that the state could restrict or prohibit the decision to terminate a pregnancy.<sup>90</sup>

Since the Supreme Court decided *Roe v. Wade* in 1973, the ability of women to choose abortion has been narrowed considerably,<sup>91</sup> always in the

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up in a woman, procure abortion, is a most fearful, tragic deed; but even that does not call for man's arbitrary jurisdiction over woman's womb.

Angela F.T. Heywood, *Body Housekeeping—Home Thrift*, 20 THE WORD 2-3 (March 1893).

<sup>87</sup> See JAMES C. MOHR, ABORTION IN AMERICA: THE ORIGINS AND EVOLUTION OF NATIONAL POLICY, 1800-1900, 20-45 (dating the first wave of abortion legislation to the period between 1821 and 1841). But see Dennis J. Horan & Thomas J. Marzen, *Abortion and Midwifery: A Footnote in Legal History*, in NEW PERSPECTIVES ON HUMAN ABORTION 199 (Thomas W. Hilgar et al. eds., 1981) (arguing that restrictions on midwives dating back to at least a 1716 New York law represent earlier attempts to restrict abortion by legislation).

<sup>88</sup> Before abortion legislation was enacted in the United States, courts referred to British common law. Under the common law, a fetus did not exist until it had quickened. "Quickening" occurred when the pregnant woman herself first perceived fetal movement. *Roe v. Wade*, 410 U.S. 113, 132-33 (1973); MOHR, *supra* note 87, at 3-4.

<sup>89</sup> "It is undisputed that at common law, abortion performed *before* 'quickening'—the first recognizable movement of the fetus *in utero*, appearing usually from the 16th to the 18th week of pregnancy—was not an indictable offense." *Roe*, 410 U.S. at 132.

<sup>90</sup> *Id.* at 163.

<sup>91</sup> States can restrict the ability of minors to choose abortion. In *Planned Parenthood v. Danforth*, 428 U.S. 52 (1976) and *Bellotti v. Baird*, 443 U.S. 622 (1979), the Supreme Court invalidated state statutes requiring parental consent to abortion for minors, but at the same time set out guidelines for valid parental consent requirements. In *H.L. v. Matheson*, 450 U.S. 398 (1981), the Court also upheld a statute requiring a physician to notify the parents of a dependent, unmarried minor before performing an abortion.

States can restrict the ability of poor women to choose abortion. In *Maher v. Roe*, 432 U.S. 464 (1977), the Court upheld a state welfare regulation that authorized Medicaid reimbursement for medical services related to childbirth but not for nontherapeutic abortions. In *Poelker v. Doe*, 432 U.S. 519, 521 (1977), the Court allowed the City of St. Louis to impose the same type of economic restrictions when it held that there was "no constitutional violation . . . in electing, as a policy choice, to provide publicly financed hospital services for childbirth without providing corresponding services for nontherapeutic abortions." And the federal government may refuse federal Medicaid funds to states for abortions "except where the life of the mother would be endangered if the fetus were

direction of reinforcing the preference for women as childbearers. For example, the Supreme Court, in upholding restrictions on federal funding of abortions, declared: "the 'government may validly choose to favor childbirth over abortion and to implement that choice by funding medical services relating

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carried to term." *Harris v. McRae*, 448 U.S. 297, 302 (1980) (quoting the Hyde Amendment, Pub. L. No. 94-439, § 209, 90 Stat. 1434 (1976)).

More recently, a broader range of restrictions has been held valid. In *Webster v. Reproductive Health Services*, 492 U.S. 490 (1989), the Court held constitutional a Missouri statute that requires all state laws be interpreted to accord unborn children the same rights enjoyed by other persons, that requires a physician who has reason to believe a woman may be 20 or more weeks pregnant to conduct viability tests before performing an abortion, that bans use of public employees and facilities to perform or assist abortions unless necessary to save the woman's life, and that bans use of public funds, employees, or facilities to counsel a woman to have an abortion. In *Rust v. Sullivan*, 111 S. Ct. 1759 (1991), the Court validated Public Health Service Act regulations specifying that a "Title X project may not provide counseling concerning the use of abortion as a method of family planning," even upon a specific request for information about abortion providers, but requiring that every pregnant client be referred "for appropriate prenatal and/or social services by furnishing a list of available providers that promote the welfare of the mother and the unborn child." *Id.* at 1776-77. Through this decision, the government's power to restrict abortion by limiting women's access to information was recognized.

The Senate and the House of Representatives responded immediately to the *Rust* decision by introducing legislation to lift its so-called gag rule and permit federally financed clinics to offer "non-directive" counseling on abortion and birth control. Philip J. Hilts, *Clinics Seek to Overturn Rule on Abortion Advice*, N.Y. TIMES, May 25, 1991, at A9. Also, the American Medical Association, which traditionally distanced itself from the abortion debate, issued a strongly worded statement condemning *Rust*, and went on record in favor of legislation designed to overturn it. James A. Barnes, *New Clash on Abortion*, NAT'L JOURNAL, June 8, 1991, vol. 23, at 1353; Anne Kornhauser, *Abortion Groups Try to Recruit AMA*, LEGAL TIMES, June 3, 1991, at 5; John Deardourff, *John Sununu and the Abortion Gag Rule*, WASHINGTON POST (editorial), Nov. 6, 1991, at A25. President Clinton issued an administrative order on January 23, 1993 lifting the federal "gag rule." 58 Fed. Reg. 7455 (1993).

In the meantime, several state legislatures have proposed or enacted laws to restrict access to abortion except for victims of incest or rape, or when necessary to save the life of the woman. See, e.g., UTAH CODE ANN. § 76-7-301.1 (1991). Most tellingly, the Supreme Court demoted the right to decide from a fundamental right to something less. In *Planned Parenthood v. Casey*, the Court held that the state can impose regulations that promote the state's interests in protecting the woman's health and potential life, unless the regulations have "the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus." In applying this "undue burden analysis" rather than strict scrutiny, the Court held valid a potentially over-exclusive statutory definition of "medical emergency," a requirement that a physician must include in the informed consent process certain information intended to dissuade women from choosing abortion, a twenty-four hour waiting period, a parental informed consent requirement, and a recordkeeping and reporting requirement. *Planned Parenthood v. Casey*, 112 S.Ct. 2791, 2819-33 (1992).

to childbirth but not those relating to abortion.”<sup>92</sup> More recently, the Justice Department intervened in abortion disputes in Virginia and Kansas. In both cases women’s clinics targeted by anti-abortion protesters invoked the Civil Rights Act of 1871 for the proposition that it is illegal for two or more persons to conspire “for the purpose of depriving any person or class of persons” from exercising their Constitutional rights. The Justice Department filed briefs in both cases contending that the 1871 law does not protect women seeking abortions.<sup>93</sup> These developments represent, in part, an expansion of the moral-legal position taken by the federal government in the abortion debate—that the state may prefer one ideological position and define motherhood.<sup>94</sup>

The legal disputes reflect the public debate which has centered on the meaning of motherhood. The pro-life arguments are tied to traditional white, middle class beliefs and values, which include the assumptions that immutable biological traits indicate our natural moral roles—motherhood for women—and that motherhood should only occur within a marriage.<sup>95</sup> The stigmatized “choices” are abortion and single motherhood. Because single motherhood is often described as a black community problem, the pro-life arguments suggest that the Good Mother model is both married and non-black.

### 3. *Sterilization Abuse*

A less visible type of conception regulation than abortion restriction is sterilization abuse. A person who voluntarily chooses to be sterilized opts not

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<sup>92</sup> *Rust v. Sullivan*, 111 S. Ct. 1759, 1766 (1991) (quoting *Rust v. Sullivan*, 889 F.2d 401, 410 (2d Cir. 1989)).

<sup>93</sup> In 1993, the U.S. Supreme Court held that the 1871 civil rights law could not be used to prosecute anti-abortion protesters from demonstrating on or near clinic grounds. *Bray v. Alexandria Women’s Health Clinic*, 113 S. Ct. 753 (1993). See also Gwen Ifill, *1871 Rights Law at Issue In a Dispute on Abortion*, N.Y. TIMES, Aug. 11, 1991, at A10.

<sup>94</sup> *Planned Parenthood v. Casey*, 112 S. Ct. 2791 (1992). Justice O’Connor’s opinion for the Court in *Casey* describes the right to decide as a motherhood issue. She defines motherhood with clear reference to the Ideology, then concludes on an inconsistent note:

The mother who carries a child to full term is subject to anxieties, to physical constraints, to pain that only she must bear. That these sacrifices have from the beginning of the human race been endured by woman with a pride that ennobles her in the eyes of others and gives to the infant a bond of love cannot alone be grounds for the State to insist she make the sacrifice. . . . The destiny of the woman must be shaped to a large extent on her own conception of her spiritual imperatives and her place in society.

*Id.* at 2807.

<sup>95</sup> KRISTIN LUKER, *ABORTION AND THE POLITICS OF MOTHERHOOD* 193–215 (1984).



to conceive, a decision fully within the scope of reproductive liberty. But if a woman is forcibly sterilized, she is deprived of that liberty.<sup>96</sup> As Part II explains, it is cultural practice to restrict the autonomy of women, and it is the ideology of motherhood that makes the practice seem both natural and morally correct. The facts indicate that women have been and are forcibly sterilized because they have violated the ideology; they have been deemed “bad” mothers.

Not surprisingly, the first forcible sterilization laws were passed as part of the Social Purity Movement.<sup>97</sup> It was during the late nineteenth and early twentieth centuries that sterilization was looked to for the control of hereditary characteristics.<sup>98</sup> “Purity” referred to race, culture, class, and intelligence as well as to morals, and each of these traits was considered to be hereditary.<sup>99</sup> Accordingly, forcible sterilization laws were seen as attempts to purify society by keeping those with weak traits from breeding.<sup>100</sup> Those with weak traits

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<sup>96</sup> See *Skinner v. Oklahoma*, 316 U.S. 535, 541 (1942). In writing for the court, Justice Douglas stated:

We are dealing here with legislation which involves one of the basic civil rights of man. Marriage and procreation are fundamental to the very existence and survival of the race. The power to sterilize, if exercised, may have subtle, far reaching and devastating effects. . . . There is no redemption for the individual whom the law touches. . . . He is forever deprived of a basic liberty.

*Id.*

<sup>97</sup> KEVLES, *supra* note 76, at 100–07; James B. O’Hara & T. Howland Sanks, *Eugenic Sterilization*, 45 GEO. L.J. 20 (1956).

<sup>98</sup> “The best minds of today have accepted the fact that if superior people are desired, they must be bred; and if imbeciles, criminals, paupers, and [the] otherwise unfit are undesirable citizens they must not be bred.” KEVLES, *supra* note 76, at 85 (quoting VICTORIA WOODHULL, *THE RAPID MULTIPLICATION OF THE UNFIT* (1891)); see also GORDON, *supra* note 7, at 120–22.

<sup>99</sup> GORDON, *supra* note 7, at 120–21. Environmental factors were not distinguished from hereditary factors in human development. All traits were assumed to be hereditary.

<sup>100</sup> See KEVLES, *supra* note 76, at 277. The idea of achieving social purity is still being expressed in terms of heredity. For example, genetic screening may be conducted to identify persons carrying deleterious genes. Testing is used to discourage those carrying genes for Tay-Sachs, sickle cell anemia, hemophilia, and cystic fibrosis from conceiving. They are considered unfit, in a sense, to become biological parents. The process can be just as stigmatizing as the prosecution of prostitutes or the sterilization abuse of poor women of color, because of the moral weight assigned to parenthood in our society. “[T]he freedom of parenthood is a freedom to good parentage, and not a license to produce seriously defective individuals to bear their own burdens.” PAUL RAMSEY, *FABRICATED MAN* 98 (1970) (Ramsey made this statement in support of his proposal that the state refuse marriage licenses to those who would transmit genetic diseases.). Interestingly, persons are stigmatized before the harm occurs—before persons who are carriers conceive a child with

were likely to be persons of color, whites of southern or eastern European stock, persons with intellectual or emotional disabilities,<sup>101</sup> persons addicted to alcohol or drugs,<sup>102</sup> and/or persons of immoral character according to the rigid social code of the day.<sup>103</sup>

The story of Carrie Buck is well-known.<sup>104</sup> Perhaps less well-known is that sterilization laws were used against prostitutes to prevent them from transmitting the traits that made them "bad" women.<sup>105</sup> Many women were institutionalized because they did not, like prostitutes, fit the ideal of true womanhood. Women who expressed their sexuality,<sup>106</sup> women who suffered

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Tay-Sachs or sickle cell anemia. Because of their potential to have defective children, carriers are treated as a risk to their would-be children and to society. Moral and legal deterrents to conception have been created as a result.

<sup>101</sup> See, e.g., KEVLES, *supra* note 76, at 100 (describing Indiana's marriage law of 1905). The statute "forbade the marriage of the mentally deficient, persons having a 'transmissible disease,' and habitual drunkards; required a health certificate of all persons released from institutions; and declared void all marriages contracted in another state in an effort to avoid the Indiana law."

<sup>102</sup> *Id.* at 99.

<sup>103</sup> *Id.* at 107.

<sup>104</sup> *Buck v. Bell*, 274 U.S. 200 (1927). The Supreme Court upheld a Virginia sterilization statute as applied to Carrie Buck. It was established that Carrie Buck, her one-month old infant, and her mother were all feeble-minded. The Court took this as proof that feeble-mindedness was hereditary. In writing for the court, Justice Holmes concluded, "Three generations of imbeciles is enough." A few years later, Carrie Buck's daughter, Vivian, died. According to her second grade teachers, she was quite bright. For further background and discussion of this case, see KEVLES, *supra* note 76, at 110-12; Charles Murdock, *Sterilization of the Retarded: A Problem or a Solution?*, 62 CAL. L. REV. 917, 920-21 (1974); O'Hara & Sanks, *supra* note 97, at 28-32; Dorothy E. Roberts, *Punishing Drug Addicts Who Have Babies: Women of Color, Equality, and the Right of Privacy*, 104 HARV. L. REV. 1419, 1473-76 (1991); Susan Stefan, *Whose Egg is It Anyway?: Reproductive Rights of Incarcerated, Institutionalized and Incompetent Women*, 13 NOVA L. REV. 404, 413-16 (1989).

<sup>105</sup> GORDON, *supra* note 7, at 121 (summarizing the rationale for sterilizing women who engaged in prostitution: "[B]ad heredity created lust which created prostitution; if prostitutes could be prevented from bearing children their ranks would not be replenished."); Holmes, *supra* note 41, at 374-76.

<sup>106</sup> Other legal practices expressed stereotypes about female sexuality in a punitive manner.

In the Progressive period the abundant literature on delinquency was riddled with stereotypical assumptions about women and, in particular, about immigrant women. These stereotypes laid a basis for more punitive treatment of delinquent girls than delinquent boys. Girls were prosecuted almost exclusively for 'immoral' conduct, a very broad category that defined all sexual exploration as fundamentally perverse and predictive of future promiscuity, perhaps even prostitution.

from postpartum depression,<sup>107</sup> and women of color<sup>108</sup> were more often deemed disturbed and in need of institutionalization. Since sterilization laws were aimed at the institutionalized, these women were more likely to be forcibly sterilized. These women did not fit within the ideal of motherhood, and so were prevented from becoming mothers.

It is still poor women of color who are most likely to be deemed unfit and subjected to sterilization abuse.<sup>109</sup> Ethnic elitism, classism, and racism all

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Steven Schlossman & Stephanie Wallach, *The Crime Of Precocious Sexuality: Female Juvenile Delinquency in the Progressive Era*, in *WOMEN, THE LAW, AND THE CONSTITUTION* 448 (Kermit L. Hall ed., 1987).

<sup>107</sup> Postpartum depression was understood to be an unnatural reaction to motherhood. It was taken as an indication that a woman's moral character was flawed. Thus, it seems that women suffering from postpartum depression were institutionalized as immoral women, not as women in need of medical care. Ellen Dwyer, *The Weaker Vessel: Legal Versus Social Reality in Mental Commitments in Nineteenth-Century New York*, in 1 *WOMEN AND THE LAW* 94-97 (1982); see also Robert T. Roth & Judith Lerner, *Sex-Based Discrimination in the Mental Institutionalization of Women*, 62 *CAL. L. REV.* 789 (1974) (describing how psychiatry today reflects the dominant society's belief in a rigidly defined female role in a way that justifies the retention and application of that belief by society and the law).

<sup>108</sup> "[J]udged by the evolving nineteenth-century ideology of femininity, which emphasized women's roles as nurturing mothers and gentle companions and housekeepers for their husbands, Black women were practically anomalies." ANGELA DAVIS, *WOMEN, RACE, AND CLASS* 5 (1981); see also Dwyer, *supra* note 107, at 88.

<sup>109</sup> Several cases of widespread sterilization abuse of women of color have been exposed in the past twenty years. Laurie Nsiah-Jefferson, *Reproductive Laws, Women of Color, and Low-Income Women*, in *REPRODUCTIVE LAWS FOR THE 1990s* 23, 46 (Sherill Cohen & Nadine Taub eds., 1989). In 1974, a federal district court found that 100,000 to 150,000 poor women had been sterilized under federally funded programs. An indefinite number of poor people were told that their welfare benefits would be withdrawn unless they submitted to sterilization. See *Relf v. Weinberger*, 372 F. Supp. 1196, 1199 (D.D.C. 1974), *modification denied sub nom. Relf v. Mathews*, 403 F. Supp. 1235 (D.D.C. 1975), *vacated*, 565 F.2d 722 (D.C. Cir. 1977). In response to the widespread publicity of *Relf*, the U.S. Department of Health, Education, and Welfare issued interim regulations protecting an adult's right of informed consent to sterilization in April 1974. But a survey conducted by the American Civil Liberties Union in 1975 revealed that 70 of the responding hospitals were ignoring these regulations.

Today, 42 U.S.C. § 300a-8 provides that public officials and authorities cannot force sterilization on beneficiaries. However, the practical effect of recent enactments is to do just that. Subchapters XIX and XX of the Social Security Act authorize matching Medicaid reimbursement for sterilization. 42 U.S.C.A. § 1396a(a)(10)(A) (West 1991); 42 U.S.C. § 1397a(a)(2) (1988). But Congress and state legislatures have restricted use of public funds, public facilities, and public employees for abortion through the Hyde Amendments. See Pub. L. No. 94-439, § 209, 90 Stat. 1434 (1976). Moreover, under Title X, information about abortions cannot even be discussed. See *Rust v. Sullivan*, 111 S. Ct. 1759 (1991). So, as Dorothy Roberts points out, "sterilization is the only publicly-funded birth control method readily available to poor women of color." Roberts, *supra* note 104, at 1444.

contribute to the fact that the sterilization rates for poor women and women of color are higher than for white women.<sup>110</sup> The attitude underlying some of these reasons is that "excessive childbearing" by poor women of color is undesirable.<sup>111</sup> In the words of Justice Holmes, "We have seen more than once that the public welfare may call upon the best citizens for their lives. It would be strange if it could not call upon those who already sap the strength of the state for these lesser sacrifices . . . in order to prevent our being swamped with incompetence."<sup>112</sup> At the same time, sterilization has been touted as fiscally good for society. The racial conservationists posit that sterilization reduces the number of persons on Medicaid who will need obstetrical services or contraceptives, and therefore reduces the demand for public resources.<sup>113</sup>

The court in *Relf v. Weinberger*, for example, found "uncontroverted evidence in the record that . . . an indefinite number of poor people have been improperly coerced into accepting a sterilization operation under the threat that various federally supported welfare benefits would be withdrawn unless they submitted to irreversible sterilization."<sup>114</sup> An estimated thirty to forty-two

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Although statistics indicate that direct sterilization abuse may have ceased, indirect means are still being used against poor women of color. See Adele Clarke, *Subtle Forms of Sterilization Abuse: A Reproductive Rights Analysis*, in TEST-TUBE WOMEN: WHAT FUTURE FOR MOTHERHOOD? 188, 200 (Rita Arditti et al. eds., 1984); Nsiah-Jefferson, *supra* note 109, at 47-48; see also Murdock, *supra* note 104 (describing how another group of women—the mentally retarded—are also vulnerable to sterilization abuse); Stefan, *supra* note 104, at 419-27. Health Research Group, a Ralph Nader-affiliated consumer organization in Washington, D.C., reported in 1973 that sterilizations were being coerced throughout the United States. The report described one method of indirect sterilization abuse—in the words of one ob/gyn, "women seem to accept the procedure more readily if the word 'operation' is not used," and the sterilization is described merely as a "stitch in the vagina." See GENA COREA, *THE HIDDEN MALPRACTICE: HOW AMERICAN MEDICINE TREATS WOMEN AS PATIENTS AND PROFESSIONALS* 182 (1973).

<sup>110</sup> Nsiah-Jefferson, *supra* note 109, at 47. By 1982, 34 percent of married black women aged 15 to 44 had been sterilized, as compared with 25 percent of white women. High sterilization rates have also been reported for Hispanic and Native American women.

<sup>111</sup> See Nsiah-Jefferson, *supra* note 109, at 47; Roberts, *supra* note 104, at 1436-44. Gena Corea reports a conversation with Dr. C., chief of surgery in a northeastern hospital: "The doctor feels that a girl with lots of kids, on welfare, and not intelligent enough to use birth control, is better off being sterilized." "Not intelligent enough to use birth control" is often a Code phrase for "black" or "poor." COREA, *supra* note 109, at 180-81.

<sup>112</sup> *Buck v. Bell*, 274 U.S. 200, 207 (1927).

<sup>113</sup> COREA, *supra* note 109, at 181 ("As physicians we have obligations to our individual patients, but we also have obligations to the society of which we are a part . . . . The welfare mess . . . cries out for solutions, one of which is fertility control."); Nsiah-Jefferson, *supra* note 109, at 47 (citing Martha Eliot Health Center, Reproductive Health Report, 1985).

<sup>114</sup> 372 F. Supp. 1199 (D.D.C. 1974).

percent of all Native Americans have been sterilized.<sup>115</sup> A recent controversy in Los Angeles, California concerned allegations of excessive sterilization of Hispanic women at public hospitals, many of whom did not speak or understand English.<sup>116</sup>

A disturbing message is sent by the excessive sterilization of poor women of color: there is an ideal for motherhood that is narrow and not easily met by those on society's fringe.<sup>117</sup> In addition, federal funding of involuntary sterilization sends the message that if anyone is to sacrifice for the good of society, it should be women; and it should be women because they are childbearers. Thus, the ideal for motherhood is still synonymous with the idea of social good, and social good is based on constructs of race and class.

#### 4. *Surrogate Motherhood*

Other means of restricting the woman's choices surrounding conception echo the same messages, but arise from more recent advances in medicine. Reproduction by surrogacy has triggered the strongest articulations of the motherhood ideology.<sup>118</sup> Judges, religious leaders, reporters, and others have condemned women who have acted as surrogates as babysellers,<sup>119</sup> as reproductive prostitutes,<sup>120</sup> and as surrogate uteri<sup>121</sup> because these women have

<sup>115</sup> ALLIANCE AGAINST WOMEN'S OPPRESSION, CAUGHT IN THE CROSSFIRE: MINORITY WOMEN AND REPRODUCTIVE RIGHTS 5 (1983).

<sup>116</sup> *Madrigal v. Quilligan*, No. CV-75-2057-JWC (C.D. Cal. June 30, 1978) (judgment for defendants in unreported case); see also Carlos G. Velez-I, *The Nonconsenting Sterilization of Mexican Women in Los Angeles*, in TWICE A MINORITY: MEXICAN AMERICAN WOMAN 235 (Margarita B. Melville ed., 1980); Helen Rodriques-Triaz, *Sterilization Abuse*, in BIOLOGICAL WOMAN—THE CONVENIENT MYTH 147, 151 (1982).

<sup>117</sup> On the other hand, those women who resemble the ideal described by the dominant culture may have trouble choosing sterilization. See Ruth Colker, *Feminism, Theology, and Abortion: Toward Love, Compassion, and Wisdom*, 77 CAL. L. REV. 1011, 1067 n.196 (1989) ("[The] . . . physician's actions reflect the dominant social message—that a healthy (white) woman should want to bear a child.").

<sup>118</sup> For a full discussion of the legal and ethical implications of surrogate motherhood, see MARTHA A. FIELD, *SURROGATE MOTHERHOOD* (1988).

<sup>119</sup> *In re Baby M*, 537 A.2d 1227, 1242 (N.J. 1988) ("The negative consequences of baby-buying are potentially present in the surrogacy context, especially the potential for placing and adopting a child without regard to the interest of the child or the natural mother."). But see *Surrogate Parenting Assocs. v. Kentucky*, 704 S.W.2d 209 (Ky. 1986) (holding that paid surrogacy arrangements do not violate anti-baby selling laws because the arrangement is made before the child is conceived).

<sup>120</sup> FIELD, *supra* note 118, at 28.

<sup>121</sup> Robert Hanley, *A Reporter's Notebook: Tactics in Baby M Trial*, N.Y. TIMES, Feb. 9, 1987, at B3.

separated biological motherhood from the role of social motherhood described by the ideology.<sup>122</sup> These speakers have vilified women acting as surrogates despite the claim by many that they find satisfaction in enabling other women to become mothers;<sup>123</sup> altruism, lauded as a maternal virtue in other contexts, is devalued when women act in ways that contradict the ideology.

The famous *Baby M* case<sup>124</sup> was publicly discussed and legally judged in ways that expressed condemnation of Mary Beth Whitehead, the woman who acted as surrogate, and Elizabeth Stern, the would-be adoptive mother. However, the discussion left the public image and legal standing of William Stern intact. The media and counsel for William and Elizabeth Stern portrayed Mary Beth Whitehead, the surrogate mother, as a disturbed woman.<sup>125</sup> Yet, if one disregards the reproductive method used, Mary Beth Whitehead acted in ways for which we normally praise mothers. She risked being held in contempt of court, she left the state of New Jersey, and she took physical risks by climbing out through a motel window to escape with her daughter.<sup>126</sup> In short, she went to great extremes to preserve the mother-child relationship.<sup>127</sup> Yet the New Jersey Supreme Court, citing the best interests of the child standard, awarded custody to the Sterns.<sup>128</sup> Elizabeth Stern was not as badly portrayed as Mary Beth Whitehead.<sup>129</sup> Yet her reason for not choosing pregnancy—fear that

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<sup>122</sup> The more substantial basis for regulating surrogacy is that it creates opportunities for degrading women, particularly poor women of color, and for commodifying human life. See *In re Baby M*, 537 A.2d at 1227; Digest of Amicus Brief of Foundation on Economic Trends et al., *In re Baby M*, at 6–10 (1987); Margaret Jane Radin, *Market-Inalienability*, 100 HARV. L. REV. 1849, 1928–36 (1987).

<sup>123</sup> See FIELD, *supra* note 118, at 20–21.

<sup>124</sup> *In re Baby M*, 537 A.2d 1227 (N.J. 1988).

<sup>125</sup> Bergen County Superior Court Judge Harvey R. Sorkow criticized Ms. Whitehead for not being able to separate her children's needs from her own. *In re Baby M*, 525 A.2d 1128 (N.J. Sup. Ct. Ch. Div. 1987). Chief Justice Wilentz, writing for the New Jersey Supreme Court, attributed the potential harmful effects of surrogacy to children to the natural mother, particularly, "the impact on the child who learns her life was bought, that she is the offspring of someone who gave birth to her only to obtain money." *In re Baby M*, 537 A.2d at 1250.

<sup>126</sup> *In re Baby M*, 537 A.2d at 1237.

<sup>127</sup> Compare the positive portrayal of Elizabeth Morgan, the woman who was jailed for hiding her child. Marlene Cimon, *Elizabeth Morgan: Life After Jail*, L.A. TIMES, Oct. 24, 1989, at E1.

<sup>128</sup> *In re Baby M*, 537 A.2d at 1258.

<sup>129</sup> The different treatment arose, in part, from class distinctions between the two potential mothers. See Katha Pollitt, *Contracts and Apple Pie: The Strange Case of Baby M*, 244 THE NATION 667, 682 (1987). The Sterns were professionals. Elizabeth Stern was a professor of pediatrics and her husband was a biochemist. Their combined yearly income approached \$90,000. *In re Baby M*, 537 A.2d at 1249. Mary Beth Whitehead was a 27-year-old housewife and mother of two, whose husband was a garbage collector. Pam

it would aggravate her multiple sclerosis—was denigrated as exaggerated.<sup>130</sup> Although Elizabeth Stern did seek to adopt the child legally, the court denied this petition.<sup>131</sup> The idea seemed to be that there was something wrong with a woman who would not take the risks of pregnancy.<sup>132</sup>

The *Baby M* case became yet another opportunity to elaborate upon the description of bad mothers. It sought to discourage women from deciding how to conceive and when to conceive by surrogacy. And the practice of regulating women as childbearers by restricting the choices surrounding conception continues. In the next subsection, I will describe how recent regulations implicate the choices a woman makes during pregnancy—after conception takes place, and after the decision to terminate the pregnancy becomes irrelevant.

### B. *Control of the Pregnancy*

Historically, the law did not restrict women's behavior during pregnancy. Pregnant women have curtailed their activities in response to the social norms of proper pregnancy behavior or the dictates of physicians. In the past few years, the state has begun stepping in to reinforce the idea that a woman should act in particular ways and for particular reasons during pregnancy. The message used to justify state intervention is that a pregnant woman is a mother who should think and act first and foremost to protect the health of the fetus she carries, and that she should do so not only to ensure a good future for the fetus, but also for society.

I have divided my discussion of restrictions into the categories of direct and indirect pregnancy regulations. Direct regulations deny the possibility that the woman has a choice. Indirect regulations suggest that the woman has a choice, but provide legal penalties if the woman makes the "wrong" choice.

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Murphy, *Outcry over 'Baby M' Ruling—Feminists Blast Decision as Exploiting Poor Women*, CHICAGO TRIBUNE, April 2, 1987, at 4. "At the time of trial, the Whitehead's net assets were probably negative. . . ." *In re Baby M*, 537 A.2d at 1249.

<sup>130</sup> "Her anxiety appears to have exceeded the actual risk, which current medical authorities assess as minimal." *In re Baby M*, 537 A.2d at 1235. The court characterized the effect of Elizabeth Stern's fears on Mr. Stern more sympathetically: "The decision had a special significance for Mr. Stern. Most of his family had been destroyed in the Holocaust. As the family's only survivor, he very much wanted to continue his bloodline." *Id.*

<sup>131</sup> *In re Baby M*, 537 A.2d at 1244–45.

<sup>132</sup> The tone in which these remarks were made is reminiscent of the earlier criticisms of educated, upper middle class women as too delicate to be good childbearers. Too much thinking apparently weakened the constitution of such women and made them less fit to be mothers.

### 1. *Direct Regulation of the Pregnant Woman*

Direct regulations of the pregnancy are usually imposed by the state via the doctor-patient relationship. That is, the state steps in to enforce the doctor's opinion that medical intervention is necessary despite the woman's decision to refuse treatment. Accordingly, I begin this section on direct regulation by describing how the decisionmaking process promotes "consent" as the choice of good mothers and refusal as the choice of unnatural women. I then discuss direct regulations.

Note that in organizing my discussion of the types of direct regulation, I have inverted the biological order of events in pregnancy. I begin by discussing regulations created in response to high risk deliveries and end by discussing issues arising before conception. Although this reverses the order in which these events occur, it does reflect the direction of the slippery slope built by law and technology. The moral-legal arguments for restricting procreative liberty which developed during the abortion debate first made a noticeable appearance in high-risk, third-trimester pregnancy situations. The push is now expanding toward requiring medical care earlier in the reproductive process and more standard (non-emergency) therapies. This trend both describes and prescribes an emerging norm—the completely regulated woman.

#### a. *The Decisionmaking Process*

A general rule of medical treatment is that doctors cannot act without the patient's informed consent.<sup>133</sup> Ideally, the doctrine of informed consent promotes patient autonomy<sup>134</sup> and preserves the professional integrity of the

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<sup>133</sup> Early statements of this principle are presented in *Union Pac. Ry. v. Botsford*, 141 U.S. 250, 251 (1891) ("No right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law.") and *Salgo v. Leland Stanford Jr. Univ. Bd. of Trustees*, 317 P.2d 170 (Cal. Dist. Ct. App. 1957) ("A physician violates his duty to his patient and subjects himself to liability if he withholds any facts which are necessary to form the basis of an intelligent consent by the patient to the proposed treatment.").

<sup>134</sup> "The root premise is the concept, fundamental in American jurisprudence, that '[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body. . . .' True consent to what happens to one's self is the informed exercise of a choice, and that entails an opportunity to evaluate knowledgeably the options available and the risks attendant upon each." *Canterbury v. Spence*, 464 F.2d 772, 780 (D.C. Cir. 1972) (quoting *Schloendorff v. Society of N. Y. Hosps.*, 105 N.E. 92, 93 (N.Y. 1914)), *cert. denied*, 409 U.S. 1064 (1972); *see also* TOM L. BEAUCHAMP & JAMES F. CHILDRESS, *PRINCIPLES OF BIOMEDICAL ETHICS* 67-113 (3d ed. 1989).



physician.<sup>135</sup> Medical and legal experts describe the doctrine as a process, "an invitation, asking for consent, seeking authorization to proceed, and not making a demand under the guise of a symbolic egalitarian gesture."<sup>136</sup> When the patient is pregnant, however, the consent process becomes more complicated. The American Academy of Pediatrics and the American College of Obstetricians and Gynecologists recognize the fetus as a separate patient.<sup>137</sup> Yet the woman is the only patient capable of giving informed consent.

Many of the fetal therapies available are new and their risks difficult to anticipate.<sup>138</sup> But so long as the decision to take the unknown risk is made under cover of informed consent, "physicians feel justified in using new 'therapies.'"<sup>139</sup> In addition, the physician who believes the proposed therapy to be the better choice may describe it in a way that emphasizes its benefits and minimizes its risks. For example, in the early 1960s doctors recommended DES to diabetic pregnant women,<sup>140</sup> had pregnant women X-rayed, limited their weight gain during pregnancy to thirteen pounds, and prescribed diuretics to them.<sup>141</sup> Doctors made these recommendations in good faith, but did so

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<sup>135</sup> Health care providers have an obligation to promote the patient's welfare, "as defined in part by the patient's own values." The informed consent process facilitates this "principle of beneficence" by provoking the patient to identify her values. See BEAUCHAMP & CHILDRESS, *supra* note 134, at 194-97.

<sup>136</sup> ROBERT J. LEVINE, *ETHICS AND REGULATION OF CLINICAL RESEARCH* 99 (2d ed. 1986) (quoting Jay Katz, *The Regulation of Human Research—Reflections and Proposals*, 21 CLINICAL RES. 785-91 (1973)).

<sup>137</sup> American College of Obstetricians and Gynecologists Committee Opinion Number 55, October 1987, *Patient Choice Maternal Fetal Conflict*.

<sup>138</sup> Ruth Hubbard, *Legal and Policy Implications of Recent Advances in Prenatal Diagnosis and Fetal Therapy*, 7 WOMEN'S RTS. L. REP. 201, 206-10 (1982).

<sup>139</sup> *Id.* at 207.

<sup>140</sup> Molly McNulty, Note, *Pregnancy Police: The Health Policy and Legal Implications of Punishing Pregnant Women for Harm to Their Fetuses*, 16 N.Y.U. REV. L. & SOC. CHANGE 277, 312 (1987-88).

<sup>141</sup> SHEILA KITZINGER, *WOMEN AS MOTHERS* 73-74 (1978); see also Richard Graham Law, *Standards of Obstetric Care: The Report of the North-West Metropolitan Regional Obstetric Survey, 1962-1964* 146 (1967) ("Where a twin pregnancy is suspected an X-ray examination of the abdomen is usually carried out in order both to confirm the diagnosis and, to a lesser extent, for other reasons . . . . If, as shown for hospital booked patients, X-ray examination of a twin pregnancy is deemed necessary, it is impossible to understand why this course was not followed [in other situations]."). LAWRENCE Q. CRAWLEY, *REPRODUCTION, SEX AND PREPARATION FOR MARRIAGE* 45 (1964) ("She is usually advised to limit the gain during pregnancy to between fifteen and twenty pounds . . . . Weight control also minimizes the chances of complications during pregnancy. The additional load that the needs of the developing child place on the mother's kidneys, heart, liver and circulation in general might be dangerously increased by the added burden placed on these same organs by sudden and excessive weight gain."); Sandra K. Danziger, *Male Doctor-Female Patient*, in *THE AMERICAN WAY OF BIRTH* 128 (1986); HELEN M. WALLACE ET AL.,

despite their lack of complete information about the risks these therapies posed. Women who refused to follow these recommendations were treated as problems.<sup>142</sup> For example, many women were told that labor must be induced "because they had put on too much or had not gained enough [weight]."<sup>143</sup> Yet in 1970, research revealed that these restrictions on weight gain increased the risk of low infant birth weight. And DES and X-rays were found to be toxic both to women and to developing fetuses.

Many women faced with a treatment decision consent for the purpose of promoting fetal health, even if doing so jeopardizes their own well-being. These consents are not challenged. They meet our expectations of good motherhood. But when a woman refuses treatment deemed by a physician as best for the fetus, both doctors and judges impute bad motive or character to her choice.<sup>144</sup> And by refusing consent she becomes a bad or "unnatural" mother.<sup>145</sup> For example, four doctors, discussing the situation in which a woman refused to consent to surgery intended to save the fetus, assumed that "the patient hopes to be freed in this way of an undesired pregnancy."<sup>146</sup> A similar article described the frustrations of the medical team: "they viewed the patient's response as one of unreasonable insensitivity to the welfare of [the] infant."<sup>147</sup> As the cases reveal, the woman may have religious reasons for refusing treatment.<sup>148</sup> She may be afraid,<sup>149</sup> or she may simply disagree with

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MATERNAL AND CHILD HEALTH PRACTICES: PROBLEMS, RESOURCES AND METHODS OF DELIVERY 324 (1973).

<sup>142</sup> KITZINGER, *supra* note 141, at 73, 117; *see also* RICHARD W. WERTZ & DOROTHY C. WERTZ, *LYING-IN: A HISTORY OF CHILDBIRTH IN AMERICA* 168 (1977).

<sup>143</sup> KITZINGER, *supra* note 141, at 73.

<sup>144</sup> *See* Lisa C. Ikemoto, *Furthering Inquiry: Race, Class, and Culture in the Forced Medical Treatment of Pregnant Women*, 59 TENN. L. REV. 487, 502-04 (1992) (reviewing the text of forced medical treatment cases and finding that doctors and judges discount the woman's voice by characterizing her as stubborn, guilty, or irrational).

<sup>145</sup> KITZINGER, *supra* note 141, at 117. Obstetricians can feel perplexed and threatened by patients who do not cooperate. In response to the patient who questions his judgment, the doctor may respond with "verbal threats that unless she relies on him she is endangering her baby's life; 'You don't want to harm your baby, do you?' or even 'Do you want to kill your baby?'" *see also* Lawrence J. Nelson et al., *Forced Medical Treatment of Pregnant Women: "Compelling Each to Live as Seems Good to the Rest,"* 37 HASTINGS L.J. 703, 720 (1986). The woman who refuses treatment will be told that she "is acting contrary to the natural bonds of affection between a mother and her soon-to-be-born child." *Id.*

<sup>146</sup> J.R. Leiberman et al., *The Fetal Right to Live*, 53 AM. J. OBSTETRICS & GYNECOLOGY 515, 515 (1975).

<sup>147</sup> Watson A. Bowes, Jr. & Brad Selgestad, *Fetal Versus Maternal Rights: Medical and Legal Perspectives*, 58 OBSTETRICS & GYNECOLOGY 209, 211 (1981).

<sup>148</sup> *See infra* notes 172-76 and accompanying text.

<sup>149</sup> *See* Bowes & Selgestad, *supra* note 147. This is the woman described in note 145 *supra* who was assumed to be an insensitive mother.

the doctor's prognosis.<sup>150</sup> The story of her imputed badness, however, is the one that prevails at law. It justifies legally-sanctioned coerced consent and, as seen in the next set of cases, court-ordered medical treatment.

The informed consent process is structured to allow or even facilitate pressuring the woman into changing her mind. The Policy on Decision-Making With Pregnant Patients at The George Washington University Hospital<sup>151</sup> provides, "this hospital's policy is to accede to the pregnant patient's preference whenever possible."<sup>152</sup> It also provides that "[i]n such a situation [one in which the woman has refused medical treatment], the attending physician should explore the reasoning behind the pregnant patient's decision."<sup>153</sup> It suggests "additional counseling (by the obstetrician and by pediatric and other appropriate specialists)."<sup>154</sup> It raises the idea that the decision might stem "from emotional or psychological difficulties," meriting psychiatric counseling to "restore the patient's decision-making capacity." And the physician is "encouraged to bring such matters to the attention of the hospital ethics committee."<sup>155</sup> Presumably, the policy is intended to ensure that the woman's decision is fully informed and that she is competent, but it also assumes that the woman is choosing incorrectly. This assumption makes the informed consent process a "demand under the guise of a symbolic egalitarian gesture."<sup>156</sup>

Doctors who feel strongly that the woman's choice is wrong<sup>157</sup> may do more than seek authorization—they may attempt to persuade her to change her mind in ways that amount to coercion. For example, the doctor may tell the patient, very frankly, that by not consenting she places the doctor in a bind,

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<sup>150</sup> See *infra* note 165 and accompanying text. There is always a chance that a doctor's diagnosis or assessment of risk may be incorrect. This is another factor that influences the informed consent process.

<sup>151</sup> This policy was developed as part of an out-of-court settlement ending a suit for medical malpractice and civil rights violations. The lawsuit was initiated by the parents of Angela Carder, who died at the hospital after undergoing a court-ordered cesarean section. See *infra* notes 167-171 and accompanying text. Christine St. Andre, hospital administrator, said the policy would serve to "keep these difficult decisions within the doctor-patient relationship" and avoid "the unnecessary and sometimes detrimental resort to courts." Linda Greenhouse, *Hospital Sets Policy on Pregnant Patients' Rights*, N.Y. TIMES, Nov. 29, 1990, at B14.

<sup>152</sup> *Policy on Decision-Making with Pregnant Patients at The George Washington University Hospital*, at 4 (1992).

<sup>153</sup> *Id.* at 3.

<sup>154</sup> *Id.*

<sup>155</sup> *Id.* at 4.

<sup>156</sup> See LEVINE, *supra* note 136.

<sup>157</sup> See, e.g., Bowes & Selgestad, *supra* note 147, at 211; Leiberman, *supra* note 146, at 515.

and that to escape the bind the doctor will get a court order.<sup>158</sup> This may influence the patient by intimidating her. Or, it may persuade her that the doctor's opinion bears great weight. In either case, she would not be giving informed consent, but acceding to authority. In some instances, the woman changes her mind when literally faced with authority—when confronted by the judge or when the court order has issued.<sup>159</sup>

### b. *Forced Cesarean Sections*

When a judge steps into the delivery room and issues an order for a cesarean section against the woman's wishes, the state regulates the pregnant woman.<sup>160</sup> Few such cases are reported.<sup>161</sup> Of the reported cases, the barebone facts are similar.<sup>162</sup> The physician determines that a vaginal delivery might harm the fetus and, sometimes, the woman. The physician then recommends a cesarean section. The pregnant woman refuses to give her informed consent. The physician consults with hospital administrators and attorneys. The administrators, in turn, locate a judge for the purpose of obtaining a court order

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<sup>158</sup> The physician in this situation faces a difficult dilemma. She has an ethical duty to care for each of her patients. If she respects the woman's decision to refuse treatment, the doctor apparently fails to fulfill her duty to the fetus. Nelson, *supra* note 145, at 704.

<sup>159</sup> See Veronika E.B. Kolder et al., *Court-Ordered Obstetrical Interventions*, 316 NEW ENG. J. MED. 1192, 1193 (1987). Of 15 petitions for court-ordered cesarean sections, 13 were granted. Of the 13 court orders, 2 were not enforced "because the patient finally agreed to the procedure." *Id.* See also Bowes & Selgestad, *supra* note 147, at 210 (The authors describe a woman who would not consent to a cesarean section despite decelerations in the fetal heart rate: "Following the court's decision, the patient, although still reluctant, became more cooperative and agreed to the induction of general anesthesia.").

<sup>160</sup> For a detailed analysis of the cases, see Ikemoto, *supra* note 144.

<sup>161</sup> Nancy K. Rhoden, *The Judge in the Delivery Room: The Emergence of Court-Ordered Cesareans*, 74 CAL. L. REV. 1951, 1951 (1986); Note, *Rethinking (M)otherhood: Feminist Theory and State Regulation of Pregnancy*, 103 HARV. L. REV. 1325, 1327 (1990); see Kolder, *supra* note 159, at 1192-93 (A national survey of court-ordered obstetrical interventions yielded reports of over 40 attempts to override a woman's refusal of therapy in a five year period, but revealed details sufficient for survey purposes in only 21 cases. Fifteen court orders sought were for cesarean sections.); see also Nancy Ehrenreich, *The Colonization of the Womb* (1993) (unpublished manuscript, on file with author) (discussing how hegemony and ideology operate in court ordered cesarean sections).

<sup>162</sup> See SHERMAN ELIAS & GEORGE J. ANNAS, *REPRODUCTIVE GENETICS AND THE LAW* 253-62 (1987); George J. Annas, *Protecting the Liberty of Pregnant Patients*, 316 NEW ENG. J. MED. 1213 (1987); Denise K. Cahalane, Note, *Court-Ordered Confinement of Pregnant Women*, 15 NEW ENG. J. ON CRIM. & CIV. CONFINEMENT 203, 218-20 (1989).

to perform the procedure. The judge rushes to the hospital, talks to the doctors and the woman, and then, in most cases, issues the order.<sup>163</sup>

The details of the women's stories often get lost in the legal analysis. The stories vary, but the doctors and the judges tend toward a single approach: intervention. The courts prefer a balancing test that accords great weight to medical opinion and fetal interests and discounts the wishes of the pregnant woman as unnatural or irrational.<sup>164</sup> The result is that widely disparate human situations are treated as problems in conformity.

The woman in *In re Madyun*<sup>165</sup> was a Muslim whose labor, according to the chief resident, was not progressing satisfactorily. Ayesha Madyun and her husband wanted to encourage the progress of a natural delivery by standing up and walking around. The doctor approached the court with a request to perform a cesarean in order to forestall an infection that could begin and cause fetal brain damage or kill the fetus. There was no evidence of infection or other risks to the fetus. But the court stated, "[n]either parent is a trained physician," and ordered the cesarean performed.<sup>166</sup> The child was born healthy, with no signs of infection.

The patient *In re A.C.*<sup>167</sup> was Angela Carder, a twenty-seven year old woman. She had been diagnosed with leukemia at age thirteen. When she became pregnant she was married and had been in remission for three years. By the twenty-sixth week of her pregnancy she was hospitalized because a

<sup>163</sup> See Kolder, *supra* note 159, at 1193. Courts granted 13 of 15 petitions for forced cesarean sections.

<sup>164</sup> This balancing reflects the patriarchal nature of the medical and legal professions. Case reports authored by doctors and lawyers evidence assumptions that the doctor's desire to intervene is rational and good, and that a woman who refuses therapy is wrong. See, e.g., Leiberman, *supra* note 146, at 515-16. This article was authored by four doctors. It begins with two case reports of fetal death following refusal of therapy by the pregnant women. In both cases, the authors make a point of characterizing the nature of women's refusal as irrational. For example, in Case 1, it is reported that "[c]esarean section was proposed to save the life of the fetus. The patient, however, stubbornly refused to submit to surgery." In the discussion section immediately following the case reports, the authors attribute each patient's refusal of therapy to "her mens rea (guilty mind)." See also Bowes & Selgestad, *supra* note 147, at 211 (discussing a case report of a forced cesarean section describing the "frustrations and anxieties of the physicians and nurses who . . . viewed the patient's response as one of unreasonable insensitivity to the welfare of her infant" and who were "bewildered and angered by her attitude and stubbornness").

<sup>165</sup> 114 DAILY WASH. L. RPTR. 2233 (1986) (D.C. Super. Ct.); George J. Annas, *Foreclosing the Use of Force: A.C. Reversed*, HASTINGS CENTER REP. 27 (July/Aug. 1990).

<sup>166</sup> The Court of Appeals of the District of Columbia affirmed the decision in an unreported order. Martha A. Field, *Controlling the Woman to Protect the Fetus*, 17 LAW, MED. & HEALTH CARE 114, 126 n.19 (1989).

<sup>167</sup> 533 A.2d 611 (D.C. 1987), *reh'g granted*, 539 A.2d 203 (D.C. 1988) (en banc), *later proceeding*, 573 A.2d 1235 (D.C. 1990) (en banc).

metastacized tumor had been discovered in her lung. And though physicians believed that the fetus would have a better chance of survival if delivered at twenty-eight weeks, Angela Carder's condition was declining rapidly. While heavily sedated, she indicated that she did not want a cesarean performed. The doctors stated that the surgery might shorten her life and that the fetus had a slim chance of survival, with a possibility of being handicapped if delivered by cesarean.<sup>168</sup>

By court order, a cesarean was performed. Both Angela Carder and the infant died soon after the surgery. Judge Nebeker, in writing the opinion that denied the Carder family's motion for stay of the cesarean section, began by stating, "[t]his opinion is written after the fact . . . . Condolences are extended to those who lost the mother and child."<sup>169</sup> The opinion reviews the trial judge's order and concludes, "the trial judge did not err in subordinating A.C.'s right against bodily intrusion to the interests of the unborn child and the state."<sup>170</sup> It concludes with the words, "we wish to express our appreciation to counsel and the trial judge for a difficult task well done despite the pressures created by time and tragic circumstances."<sup>171</sup>

Jessie Mae Jefferson sought prenatal care at Griffin Spalding County Hospital.<sup>172</sup> The doctor examined her and found that she had a complete placenta previa. After the doctor informed her "that it is virtually impossible that this condition will correct itself prior to delivery; and that it is a 99% certainty that the child cannot survive natural childbirth," and that "the chances of . . . surviving vaginal delivery are not better than 50%,"<sup>173</sup> Ms. Jefferson refused the recommended cesarean delivery. She cited her religious belief "that the Lord has healed my body and that whatever happens to the child will be the Lord's will."<sup>174</sup> The court found that the unborn "child is without proper parental care and subsistence necessary for his or her physical life and health," and granted temporary custody to the state with full authority to consent to surgical delivery.<sup>175</sup>

When the superior court granted the petition of the Department of Human Resources for custody of the unborn child, the Jeffersons brought a motion for stay. In denying the motion, the Georgia Supreme Court affirmed the lower court's finding "that the intrusion involved into the life of Jessie Mae Jefferson and her husband, John W. Jefferson, is outweighed by the duty of the State to

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<sup>168</sup> *Id.* at 612.

<sup>169</sup> *Id.* at 611.

<sup>170</sup> *Id.* at 617. Upon rehearing en banc, the court stated that a substituted judgment standard, not a balancing test, should be used.

<sup>171</sup> *Id.*

<sup>172</sup> *Jefferson v. Griffin Spalding County Hosp.*, 274 S.E.2d 457, 458 (Ga. 1981).

<sup>173</sup> *Id.*

<sup>174</sup> *Id.* at 459.

<sup>175</sup> *Id.*

protect a living, unborn human being from meeting his or her death before being given the opportunity to live.”<sup>176</sup> The lower court had also ordered her to submit to a sonogram, and if the sonogram indicated a complete placenta previa, a cesarean section. Jessie Mae Jefferson delivered the child vaginally after the scan revealed that the condition no longer existed.

A Nigerian woman, name unknown, pregnant with triplets, refused to consent to a cesarean although the doctor recommended that such a delivery would be safer for multiple births.<sup>177</sup> This woman believed that a natural delivery would be safe for her. In addition, she and her husband planned to return to Africa, to an area where a cesarean delivery might not be possible should they have children later. They wanted to prevent future complications caused by use of cesarean section. The hospital obtained a court order to perform a cesarean, but the woman was not told of it until she went into labor. When she and her husband resisted, seven security officers forced the husband from the hospital. The woman was tied to the bed while struggling and screaming, and a forced cesarean was performed. The woman and the three infants survived the surgery.

These cases continue the trend begun in the early twentieth century for increased medical intervention during delivery.<sup>178</sup> Until 1938,<sup>179</sup> most women delivered their children at home, with the help of their mothers, sisters, female friends, and sometimes a midwife.<sup>180</sup> It was a time of women helping women, and the woman giving birth was an active participant in the process.<sup>181</sup> It was a

<sup>176</sup> *Id.* at 460.

<sup>177</sup> Kolder, *supra* note 159, at 1193; Janet Gallagher, *Prenatal Invasions & Interventions: What's Wrong with Fetal Rights*, 10 HARV. WOMEN'S L.J. 9, 9-10 (1987).

<sup>178</sup> See WERTZ & WERTZ, *supra* note 142, at 46-47. For a comprehensive history of childbirth in the United States, see JUDITH W. LEAVITT, *BROUGHT TO BED: CHILDBEARING IN AMERICA 1750 TO 1950* (1986). For discussions of the increased influence of the medical profession in general, see GENA COREA, *THE MOTHER MACHINE* 305-09 (1985); HALLER & HALLER, *supra* note 13, at x-xii, and BARBARA EHRENREICH & DEIRDRE ENGLISH, *FOR HER OWN GOOD: 150 YEARS OF THE EXPERTS' ADVICE TO WOMEN* 69-98 (Anchor Books ed., 1979) (By the late nineteenth century . . . science was well on its way to becoming a sacred national value.).

<sup>179</sup> “By 1938, half of American births occurred within medical institutions.” LEAVITT, *supra* note 178, at 205. “By 1939 half of all women and 75 percent of all urban women were delivering in hospitals.” WERTZ & WERTZ, *supra* note 142, at 133.

<sup>180</sup> “Midwives traditionally played a noninterventionist, supportive role in the home birthing rooms.” LEAVITT, *supra* note 178, at 38; WERTZ & WERTZ, *supra* note 142, at 11-26.

<sup>181</sup> WERTZ & WERTZ, *supra* note 142, at 13-18. For example, a woman usually labored in the posture and place most comfortable to her. Unlike Ms. Madyun, she was able to move about and assume a variety of positions to help her labors along. Midwives and other female attendants often brought “food and drink for the laboring woman to keep up her strength, offering such things as toast, buckwheat gruel, mutton, broth, and eggs.” *Id.* at

time when childbirth was individualized. The persons attending the birth responded to the pregnant woman as daughter, sister, and friend.<sup>182</sup> With the advent of physician-attended hospital deliveries, control of the birth process shifted to the physician,<sup>183</sup> childbirth became routinized,<sup>184</sup> and intervention became standard.<sup>185</sup>

History shows that intervention often occurs for the sake of intervention,<sup>186</sup> and, as in *Madyun*, with no specific evidence of necessity. The increase in intervention has consistently been explained by referring to fetal interests.<sup>187</sup> In 1920, DeLee recommended that episiotomies and forceps be used to facilitate every delivery to protect the fetus from risks created by compression of the brain during labor.<sup>188</sup> DeLee made his recommendations despite evidence that increased use of forceps during this period resulted in increased maternal mortality rates. In 1981, the *Jefferson* court wrote, "Jessie Mae Jefferson is Ordered to submit to a Caesarean section and related procedures considered necessary by the attending physician to sustain the life of this child."<sup>189</sup> Recognition of the fetus has reached the point where the fetus is considered a

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15. And attendants were advised to "instruct and comfort the party, not only refreshing her with good meat and drink, but also with sweet words, giving her good hope of a speedy deliverance, encouraging and admonishing her to patience and tolerance . . ." *Id.* at 17 (quoting THOMAS RAYNALDE, *THE BYRTH OF MANKIND* 97 (1626)).

<sup>182</sup> LEAVITT, *supra* note 178, at 87.

<sup>183</sup> "As long as birth remained a home-based event, . . . women continued actively to participate in the determination of confinement practices." LEAVITT, *supra* note 178, at 87. However, by the twentieth century, "women giving birth within hospitals found their capacity to determine events in the birthing of their children severely limited by the hospital environment." *Id.* at 205. For a personal account of this transfer of control over childbirth and pregnant women from a lay midwife's perspective, see generally ONNIE LEE LOGAN, *MOTHERWIT: AN ALABAMA MIDWIFE'S STORY* (1991).

<sup>184</sup> See WERTZ & WERTZ, *supra* note 142, at 165. For a description of childbirth as an assembly line, see ROTHMAN, *supra* note 14, at 86.

<sup>185</sup> "Interventions grew steadily in number after 1900." WERTZ & WERTZ, *supra* note 142, at 143. See also KITZINGER, *supra* note 141, at 116-34; COREA, *supra* note 178, at 304 ("[T]he active management of labor necessitates that obstetricians take over, not just a single aspect of responsibility but the whole process of parturition. Our control of the situation must be complete." (citing Dr. John M. Beazley, *The Active Management of Labor*, 122 AM. J. OBSTETRICS AND GYNECOLOGY, 161 (1975))).

<sup>186</sup> "Many physicians felt pressed, if their time was limited and other patients were waiting, to use forceps, anesthesia, or both to direct labor into patterns under their control." LEAVITT, *supra* note 178, at 120; see also WERTZ & WERTZ, *supra* note 142, at 161.

<sup>187</sup> Between 1915 and 1930, a time when hospital deliveries were increasing, maternal mortality did not decline, and the number of infant deaths from birth injuries increased by 40-50%. Reports cited excessive intervention as one of the reasons. WERTZ & WERTZ, *supra* note 142, at 161. Mortality rates did not begin to drop until 1936. *Id.* at 164.

<sup>188</sup> See LEAVITT, *supra* note 178, at 179; WERTZ & WERTZ, *supra* note 142, at 141.

<sup>189</sup> *Jefferson v. Griffith Spalding County Hosp.*, 274 S.E.2d 457, 460 (Ga. 1981).



second patient.<sup>190</sup> But as this has happened, the idea that maternal and fetal interests usually coincide has become more remote while the idea that maternal and fetal interests often conflict has become the dominant picture.<sup>191</sup> Concurrently, the possibility that women can define pregnancy for themselves, as something other than an inevitable conflict, is disappearing.

As the focus on conflict becomes sharper, it is being decided that the fetus is to be the primary patient, and that intervention even in the face of the woman's protest is the rule.<sup>192</sup> The *Madyun* court wrote, "All that stood between the Madyun fetus and its independent existence, separate from its mother was, put simply, a doctor's scalpel." George Annas has interpreted the statement to mean "that if a doctor believes a surgical procedure is necessary [for the fetus], and has the means to perform it, he should be able to perform it even if the woman competently refuses."<sup>193</sup> The *Jefferson* opinion yields the same principle of subordination. In *Jefferson*, the Georgia Supreme Court affirmed the superior court's determination that "[b]ecause the life of defendant and of the unborn child are, at the moment, inseparable, the Court deems it appropriate to infringe upon the wishes of the mother to the extent it is necessary to give the child an opportunity to live."<sup>194</sup> Cases like this make clear the current trend: Fetal interests will continue to trump those of the woman.

What is new about the stories of Ayesha Madyun, Angela Carder, Jessie Mae Jefferson, and the woman from Nigeria is that judges have joined doctors in the delivery room to referee the conflict. Underlying the court's balancing-test language is a set of assumptions—that a normal woman would do anything for the sake of her unborn child even if it endangered her own life; that there must be something wrong with the woman who refuses consent; that doctors and lawyers who call for intervention speak with authority and know better than the woman who refuses consent to cesarean surgery. These assumptions speak of subordination as natural and rational—women naturally subordinate their own interests to others, and rational others may subordinate the interests of those rare women who refuse to do it on their own. These assumptions lead

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<sup>190</sup> The fourteenth edition of Williams Obstetrics was issued in 1971. It described the two-patient model for pregnancy. "Since World War II and especially in the last decade, knowledge of the fetus and his environment has increased remarkably. As an important consequence the fetus has acquired status as a patient to be cared for by the physician as he long has been accustomed to caring for the mother." J. WHITRIDGE WILLIAMS, WILLIAMS OBSTETRICS 199 (L.M. Hellman & J.A. Prichard eds., Meredith Publishing Corp., 1971); Bowes & Selgestad, *supra* note 147, at 209 ("The care of a pregnant woman involves 2 patients, the mother and the fetus.").

<sup>191</sup> See *infra* notes 474-78 and accompanying text.

<sup>192</sup> See also ROTHMAN, *supra* note 14, at 85-86.

<sup>193</sup> Annas, *supra* note 165, at 28.

<sup>194</sup> *Jefferson*, 274 S.E.2d at 458.

to the conclusion that we should and can intervene to protect the innocent fetus from the bad mother. So, in the nineteenth century, women who reacted during childbirth in fear, from personal belief or other reasons, were known as Ann or Sally. From the late nineteenth century, they became known as patients or problems.<sup>195</sup> And since the 1980s, these women have become defendants.

### c. *Forced Hospital Delivery*

Other attempts to restrict choices surrounding childbirth go to the birth location and the level of standard medical intervention required. There are no laws requiring that all births take place in a hospital. But the law has mandated hospital deliveries for high-risk pregnancies. In *Jefferson*, the court awarded custody of the fetus to the Department of Human Resources of Family and Children Services as a way of making sure that Jessie Mae Jefferson would deliver at the hospital.<sup>196</sup> In yet another forced cesarean case, a Michigan judge ordered a woman to admit herself to the hospital by a certain date and time. The order included directions to the local police to pick her up should she not appear at the hospital and a mandate to the woman to submit to "whatever the medical personnel deemed appropriate, including a cesarean section and medication."<sup>197</sup> Regulations on home births<sup>198</sup> and use of midwives<sup>199</sup> are less

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<sup>195</sup> KITZINGER, *supra* note 141, at 72. The pregnant woman becomes a "patient" in the same way that anyone who is ill or who suffers a handicap becomes the object of medical attention. The recording and monitoring of the pregnancy is taken over by professionals who are not themselves part of the community in which the mother lives, and family and friends are powerless to affect it one way or another. See also MARGARETE SANDELOWSKI, PAIN, PLEASURE, AND AMERICAN CHILDBIRTH: FROM THE TWILIGHT SLEEP TO THE READ METHOD, 1914-1960 8 (1984); WERTZ & WERTZ, *supra* note 142, at 136.

<sup>196</sup> *Jefferson*, 274 S.E.2d at 459.

<sup>197</sup> Gallagher, *supra* note 177, at 47 (citing Flanigan, *Fleeing the Law: A Matter of Faith*, DET. FREE PRESS, June 29, 1982, at 3A; Flanigan, *Mom Follows Belief, Gives Birth in Hiding*, DET. FREE PRESS, June 28, 1982, at 3A). The woman and her family fled into hiding. Two weeks later, a healthy boy weighing over nine pounds was born in a vaginal birth.

<sup>198</sup> Although home births account for only a small percentage of total births, an increasing number of families are choosing homebirth over traditional hospital delivery. Charles Wolfson, *Midwives and Home Birth: Social, Medical, and Legal Perspectives*, 37 HASTINGS L.J. 909, 911 (1986). Home birth not only allows the mother to deliver in a familiar and comfortable setting, it also provides her with greater control over the birthing process. Opponents of home birth argue that complications can arise, even in low-risk pregnancies, which cause injury to the child, and which could have been prevented in a hospital. Some critics go so far as to suggest that such an injury constitutes child abuse or neglect. *Id.* at 935.

direct, but have the same effect. These regulations tell women that they have little or no control over choices surrounding childbirth. The regulations also tell women that they have little or no authority over their lives.

#### d. *Forced Life Support*

The right to refuse treatment includes, for most persons, the right to refuse life-sustaining treatment.<sup>200</sup> One way of exercising that right is to use a living will. Authorized by a natural death act,<sup>201</sup> a living will directs the caregiver to refrain from using artificial life support should the person become terminally ill or enter a persistent vegetative state. The purpose of the instrument is to effect a person's decisional autonomy and maintain her bodily integrity. However, most of the natural death acts suspend the right of pregnant women to refuse life-prolonging treatment. Most of the twenty-seven statutes containing pregnancy clauses suspend the right through the entire pregnancy. As a result, a woman who has just conceived and who is terminally ill or enters into a persistent vegetative state could be forced to undergo treatment for the next nine months of her life.<sup>202</sup> Such a woman forfeits the power literally to control her life.

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Although no state actually requires a woman to give birth in a hospital, recent notions of fetal rights and the threat of civil or criminal liability, make home birth a disfavored alternative, both legally and socially. *Id.* at 931–34.

<sup>199</sup> Prior to the 1800s, childbirth was traditionally an experience shared by women and attended by midwives who supervised the labor and delivery. LEAVITT, *supra* note 178, at 36–37. Because birth was viewed as a natural process, midwives were not required to have any special training, and there were few, if any, rules regulating their practice. Kerry L. Reilly, Note, *Midwifery in America: The Need for Uniform and Modernized State Law*, 20 SUFFOLK U.L. REV. 1117, 1118–20 (1986). However, as the birthing process moved from the home into the hospital, the demand for midwife services decreased. Thus, the elimination of the practice of midwifery was a corollary to the increase of physician control of the birth process. See EHRENREICH & ENGLISH, *supra* note 178, at 94; KITZINGER, *supra* note 141, at 95–97; WERTZ & WERTZ, *supra* note 142, at 144–48.

By the late nineteenth and early twentieth centuries, many states required some form of licensing or registration for midwives. In many states, however, the licensing requirements were so strict that although the practice of midwifery was not directly prohibited, it was effectively eliminated. Reilly, *supra* at 1123–24. See Charles Wolfson, *supra* note 198, at 958–60 for a state by state summary of laws regulating midwifery.

<sup>200</sup> *Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. 261 (1990).

<sup>201</sup> The California legislature enacted the first natural death act in 1976. California Natural Death Act, CAL. HEALTH & SAFETY CODE §§ 7185–94 (West Supp. 1991).

<sup>202</sup> To date, there are no reported cases in which a court has enforced or refused to enforce the living will of a pregnant woman. In *DiNino v. State ex rel. Gorton*, 684 P.2d 1297 (Wash. 1984), Joann DiNino sought a declaratory judgment that the pregnancy clause in Washington's natural death act was unconstitutional in light of *Roe v. Wade*. The court refused to determine the statute's constitutionality because Ms. DiNino was neither pregnant

e. *Forced Prenatal Treatment*

i. *Current Law*

Court-ordered pre-birth medical intervention reflects the same history and is based on the same legal analyses as the forced cesarean cases. Again, the courts have proven uniformly willing to step into the delivery room and remain there. In a 1987 national survey, Kolder, Gallagher, and Parsons found that court orders had been obtained for cesarean sections in ten states, for hospital detentions in two states, and for intrauterine transfusions in one state. Among twenty-one cases in which court orders were sought, the orders were obtained in eighty-six percent of the cases. In eighty-eight percent of those cases, the orders were received within six hours.<sup>203</sup>

Judge Lonschein's opinion in *In re Jamaica Hospital*<sup>204</sup> describes, in terms of procedure and the mindsets and daily lives of judges and physicians, how court orders are often obtained. As the first point of interest, note that the judge wrote the opinion entirely in first person. This device invites reader empathy, as well as reader alliance, with the judge and other professionals in the story. The invitation is strengthened by his practice of referring to the attorney and doctors by name, but to the woman as "the patient." Judge Lonschein begins his opinion with the words "[t]his past Saturday evening . . . , while I was getting dressed for a dinner engagement, I received a telephone call at my home . . . ." <sup>205</sup> He goes on to say that the call was from an attorney representing Jamaica Hospital. A half hour later, Judge Lonschein is at the hospital. He then meets with the attorney and doctor, orders a bedside hearing, hears the doctor again, speaks with the woman, and appoints the doctor as special guardian to the fetus with "discretion to do all that in his medical judgment was necessary to save its life, including the transfusion of blood into the mother." <sup>206</sup>

It is not clear from the written opinion whether this order was issued within six hours. The opinion does indicate the relative weight given the doctors' and the woman's views. Four long paragraphs are used to describe the medical opinion. In these four paragraphs, Judge Lonschein repeats that the woman was eighteen weeks pregnant (twice), suffering from internal bleeding

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nor terminally ill. For further discussion on the constitutionality of pregnancy clauses in natural death acts, see Elizabeth Carlin Benton, Note, *The Constitutionality of Pregnancy Clauses in Living Will Statutes*, 43 VAND. L. REV. 1821 (1990); Janice MacAroy Snitzer, Note, *Pregnancy Clauses in Living Will Statutes*, 87 COLUM. L. REV. 1280 (1987).

<sup>203</sup> Kolder, *supra* note 159.

<sup>204</sup> *In re Jamaica Hospital*, 491 N.Y.S.2d 898 (N.Y. Sup. Ct. 1985).

<sup>205</sup> *Id.* at 898, 899.

<sup>206</sup> *Id.* at 900.

(twice), and in need of a blood transfusion to save her life (three times), and the fetus' life (four times).<sup>207</sup> In one short paragraph, the judge describes the patient's view: "I spoke with the patient and advised her who I was and the purpose of the hearing. I asked her if she would consent to a blood transfusion. She told me, in effect, that because of her religion she would not."<sup>208</sup> He describes the woman as a single mother of ten children whose only next of kin was a sister who was unavailable.<sup>209</sup> He describes the eighteen-week fetus as "a potentially viable human being in a life-threatening situation"<sup>210</sup> and as "a human being, to whom the court stands in *parens patriae*."<sup>211</sup> Also, as in the majority of cases, the judge determined that "the state has a highly significant interest in protecting the life of a mid-term fetus, which outweighs the patient's right to refuse [medical treatment]."<sup>212</sup>

In addition to ordering blood transfused into pregnant women, the courts have also ordered women to undergo the cerclage or "purse string" surgery<sup>213</sup> and detention during pregnancy. Kolder, Gallagher, and Parsons found that three court orders for hospital detention were sought in Colorado and Illinois. The courts granted one order in each state.<sup>214</sup> The women subject to the orders were both diabetic and in their third trimester. The woman not ordered detained in a hospital was possibly in her second trimester.<sup>215</sup> These results indicate that the courts considering hospital detention may be balancing maternal-fetal interests in light of *Roe v. Wade*.<sup>216</sup> In other cases, however, it

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<sup>207</sup> *Id.* at 899.

<sup>208</sup> *Id.*

<sup>209</sup> *Id.*

<sup>210</sup> *Id.*

<sup>211</sup> *Id.* at 900.

<sup>212</sup> *Id.*; see also *Raleigh Fitkin-Paul Morgan Memorial Hosp. v. Anderson*, 201 A.2d 537 (N.J.), *cert denied*, 377 U.S. 985 (1964) (New Jersey Supreme Court held that the state's interest in the life of the fetus justified the order of a blood transfusion for the mother).

<sup>213</sup> *Taft v. Taft*, 446 N.E.2d 395 (Mass. 1983) (husband sought a court order to force a woman in her fourth month of pregnancy to submit to surgery to have her cervix sewn closed to prevent a probable miscarriage. The woman objected based on religious beliefs as a "born again Christian." The lower court ordered surgery. The Massachusetts Supreme Court vacated the order, stating that no state interest had been presented which justified restricting the woman's right of privacy. The opinion implies that the state's interest might have been established if enough evidence had been presented. "The record is devoid of facts . . . [N]o findings, based on expert testimony, describing the operative procedure, stating the nature of any risks . . . [N]o showing of the degree of likelihood that the pregnancy will be carried to term without the operation," *id.* at 397.).

<sup>214</sup> Kolder, *supra* note 159, at 1193.

<sup>215</sup> *Id.*

<sup>216</sup> *Id.* at 1194; see also Cahalane, *supra* note 162, at 204, 209-10, 212-17, 221-22.

appears that the state is simply acting to protect fetuses from women the state has deemed bad.

In *In re Steven S.*,<sup>217</sup> the Los Angeles County Department of Public Social Services (DPSS) filed a writ to have Kay S. involuntarily committed to receive intensive psychiatric treatment, and filed a dependent child petition for her fetus. The juvenile court dropped the former for lack of evidence. But it went ahead and ordered "the unborn fetus, and accordingly [Kay S.], detained. . . ."<sup>218</sup> The mental health commitment would have been ordered "for no more than 14 days."<sup>219</sup> The juvenile court's order continued until Kay S. gave birth on June 23, 1980, nearly two months after the order issued. On appeal, the court determined that "DPSS should not have been permitted to use a dependent child petition in the juvenile court as a basis for confining appellant to protect the unborn fetus."<sup>220</sup> But by then Kay S. had already been detained and the child born.

In *United States v. Vaughn*,<sup>221</sup> Brenda Vaughn pled guilty to forging several checks. Because this was her first offense, the prosecutor recommended probation. But she was pregnant and had tested positive for cocaine. The judge sentenced her to jail for 180 days. He also provided for a reduced sentence after the baby was born. At the sentencing hearing, Judge Peter Wolf told Ms. Vaughn, "You've got a cocaine problem and I'm not going to have this baby born addicted."<sup>222</sup> He then announced, "I'm going to keep her locked up until the baby is born because she's tested positive for cocaine when she came before me. She's apparently an addictive personality, and I'll be darned if I'm going to have a baby born that way."<sup>223</sup> After thirty days in jail, Brenda Vaughn reported that she had lost weight in jail and that she had refused "a couple of opportunities to go get high" in jail.<sup>224</sup>

A consistent refrain that runs through these cases is that, in order to protect the fetus, the state may subordinate the interests of the woman even by imprisonment. Yet in a significant percentage of these cases, the efforts to protect the fetus have proven pointless or even harmful. Ms. Madyun's child was born without infection. Angela Carder and her twenty-six-week-old fetus died. Jessie Mae Jefferson delivered naturally. The father of the Nigerian triplets committed suicide a few weeks after being ejected from the hospital. Kay S. disappeared after being released and losing custody of Steven S.

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<sup>217</sup> 178 Cal. Rptr. 525 (Ct. App. 1981).

<sup>218</sup> *Id.* at 526.

<sup>219</sup> *Id.*

<sup>220</sup> *Id.* at 528.

<sup>221</sup> 117 DAILY WASH. L. REP. 441 (1989) (D.C. Super. Ct.).

<sup>222</sup> Debra Cassens Moss, *Pregnant? Go Directly to Jail*, A.B.A. J., Nov. 1, 1988, at 20.

<sup>223</sup> *Id.*

<sup>224</sup> *Id.*

Brenda Vaughn retained access to drugs and lost access to prenatal care when Judge Wolf sent her to jail. It seems clear that forced intervention does not provide any degree of real protection for fetuses.<sup>225</sup>

What becomes clear, however, is that direct pregnancy regulations are a way of labeling certain women "bad mothers." These are women who have failed to act selflessly for the sake of others, as a good mother should. In addition, many of these women violate the motherhood ideology by reason of their race and social status. Of the women subject to the court orders reported in a 1987 survey, eighty-one percent were black, Asian, or Hispanic. Forty-four percent were unmarried. Twenty-four percent did not speak English as their primary language. All were seen at a teaching-hospital clinic or were receiving public assistance.<sup>226</sup> These facts echo the evidence regarding women subject to sterilization abuse,<sup>227</sup> and indicate that while the concern for protecting fetuses is beneficent, the state is more likely to regulate women as childbearers when the women do not fit the socially-constructed ideal of prosperous white motherhood.

## ii. *Proposed Regulatory Extensions*

Case law and scholarship indicate that direct regulation of pregnant women will continue,<sup>228</sup> and the regulatory scheme will continue to express the ideology of motherhood. The same legal analyses used in the forced cesarean, forced transfusion, forced cerclage, and forced detention cases could be used to support other court-ordered fetal therapies. For example, if courts are willing to order women to undergo blood transfusions, courts might also be willing to

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<sup>225</sup> In some cases, it is difficult to believe that protection of the fetus was really intended. Judge Wolf stated loudly and clearly that he wanted to protect the child from Brenda Vaughn's addictive personality. But he must have known, especially as a judge in a metropolitan area, that drugs are readily available in jail. Both the case law and the media have made it clear that jails are unhealthy places for fetuses. See Elizabeth Ross, *State's Limited Drug Treatment for Women Mirrors Problem in Nation*, CHRISTIAN SCI. MONITOR, Dec. 21, 1990, at 4.

In the cases initiated by doctors and hospitals, much of the discussion of the forced treatment cases has been devoted to potential liability. See Bowes & Selgestad, *supra* note 147, at 211 (The authors describe administrative concerns in a forced cesarean case: "In addition there was concern that the patient's family would bring charges of professional or institutional negligence in the event the infant or the mother died or was seriously injured as a result of inaction. On the other hand, there was serious concern over possible charges of criminal assault or violation of the patient's rights of privacy if an operation were performed against her will.").

<sup>226</sup> Kolder, *supra* note 159, at 1193.

<sup>227</sup> See *supra* notes 100-17 and accompanying text.

<sup>228</sup> See Gallagher, *supra* note 177, at 37-41 (discussing the "trend" toward fetal rights).

order women to submit to vitamin therapy to correct vitamin-dependent enzyme deficiencies. If courts are willing to order women to hospitals for delivery, or to jail until delivery, courts may order women with high risk pregnancies to hospitals throughout pregnancy. This is no mere fanciful slippery slope. During the nineteenth century, strict sexual mores and fears about "prenatal impressions"<sup>229</sup> manifested themselves as the social custom of requiring pregnant women to stay home during pregnancy. Today, it seems possible that strict pro-fetal mores may manifest themselves with a similar legal requirement.

It was noted earlier that the courts appear to decide these cases by balancing maternal and fetal interests in light of *Roe v. Wade*. Legal scholars have produced a variety of legal analyses that elaborate upon the *Roe* balancing test.<sup>230</sup> These analyses yield regulatory schemes that vary in scope. But the analysis always begins by describing the interests of woman and fetus, and by constructing a conflict in which those interests weigh against each other.<sup>231</sup> The weighing is performed in a way that labels all women as "childbearers." The result of the weighing is that women marginalized by the dominant culture are more likely to be labeled "bad mothers."

#### (A) *Weighted Balancing: The Analytical Framework*

The balancing test is usually articulated in constitutional terms—as a weighing of the woman's interests in decisional autonomy and bodily integrity<sup>232</sup> against the interest of the state in protecting fetal life. *Roe v. Wade* is sometimes used to support the idea that the state can intervene to protect fetal rights.<sup>233</sup> Justice Blackmun, writing for the court in *Roe v. Wade*, said that the state's interest in protecting potential human life outweighed the woman's interests upon viability.<sup>234</sup> Using this part of the opinion, courts could order a variety of fetal therapies during the third trimester. In order to be consistent

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<sup>229</sup> See WERTZ & WERTZ, *supra* note 142, at 79, 80. "The term 'confinement' by which Victorians commonly described pregnancy and lying-in, expressed the shame and impropriety of exposure during pregnancy, for the expectant woman separated herself and kept to her home. . . ." *Id.* See *infra* notes 272–73 and accompanying text.

<sup>230</sup> But see Field, *supra* note 166, at 123–24 (explaining "why the trimester system that applies to abortion has no application to controls on the mother-to-be").

<sup>231</sup> For further discussion on how and why this conflict is constructed, see *infra* notes 473–78 and accompanying text.

<sup>232</sup> See Maxwell Stearns, *Maternal Duties During Pregnancy: Toward a Conceptual Framework*, 21 NEW ENG. L. REV. 595, 606–09 (1985–86).

<sup>233</sup> But see Gallagher, *supra* note 177, at 16 (arguing that "*Roe* is more appropriately viewed as a patient's rights precedent than as establishing a state interest in the fetus").

<sup>234</sup> *Roe v. Wade*, 410 U.S. 113, 163, *reh'g denied*, 410 U.S. 959 (1973). Viability ordinarily occurs at the beginning of the third trimester. *Id.*



with the *Roe* trimester analysis, however, intervention would not be permitted when it threatened the life of the woman.<sup>235</sup>

A stronger version of this argument states that if a woman forgoes the abortion decision she waives her own interests and acquires an affirmative duty to protect the fetus.<sup>236</sup> Some would find a waiver only upon viability, the point at which the state can prohibit abortion.<sup>237</sup> Even stronger versions of the argument, however, would find a waiver as soon as the woman made an unequivocal decision to not terminate the pregnancy.<sup>238</sup> If this decision occurs at the time of conception, the state could enforce a duty to the fetus throughout the entire pregnancy. Some would find a maternal duty to the fetus before viability and before the abortion decision had been made.

Academics have detailed the description of maternal duties and fetal rights with reference to cases they consider related, such as cases concerning the right to refuse medical treatment. In particular, cases in which the courts must decide whether a person should donate an organ to another have been deemed relevant to the maternal-fetal conflict. Fetal rights proponents use *Hart v. Brown*<sup>239</sup> and *Strunk v. Strunk*<sup>240</sup> for the proposition that one person may be compelled to undergo medical treatment for the sake of another. "It can thus be argued that *Strunk* provides a legal precedent for compelling parents to undergo invasive medical procedures, including organ donation and fetal surgery, for the sake of their children."<sup>241</sup> However, maternal rights proponents cite *McFall v. Shimp*<sup>242</sup> and *In re Guardianship of Pescinski*<sup>243</sup> to make the opposite point.

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<sup>235</sup> *Id.* at 163–64 ("If the State is interested in protecting fetal life after viability, it may go so far as to proscribe abortion during that period, except when it is necessary to preserve the life or health of the mother."); Stearns, *supra* note 232, at 624.

<sup>236</sup> *But see* ELIAS & ANNAS, *supra* note 162, at 259–63 (opposing forced treatment for a number of reasons and explaining why the waiver argument is not persuasive).

<sup>237</sup> Stearns, *supra* note 232, at 624.

<sup>238</sup> John Robertson, *The Right to Procreate and In Utero Fetal Therapy*, 3 J. LEGAL MED. 333, 361 (1982).

<sup>239</sup> 289 A.2d 386 (Conn. 1972) (The Connecticut court used substituted judgment to decide that parents of a seven year old identical twin could authorize a kidney transplant necessary to the other twin's survival.).

<sup>240</sup> 445 S.W.2d 145 (Ky. Ct. App. 1969) (The court authorized a kidney transplant from a twenty-seven year old man who was institutionalized in a state school for the "feeble-minded" to his twenty-eight year old brother.).

<sup>241</sup> Deborah Mathieu, *Respecting Liberty and Preventing Harm: Limits of State Intervention in Prenatal Choice*, 8 HARV. J.L. & PUB. POL'Y 19, 44 (1985). Counsel for the Colorado hospital, mentioned in Bowes & Selgestad, also cited *Hart* and *Strunk* as authority for a forced cesarean. Bowes & Selgestad, *supra* note 147, at 212–13.

<sup>242</sup> 10 Pa. D. & C.3d 90 (1978) (A thirty-nine year old man terminally ill with aplasia anemia petitioned for a court order to compel a cousin to be tested for tissue compatibility and to donate bone marrow if compatible. The trial court denied the petition.); *see also* Nelson, *supra* note 145, at 754–55.

"If our society will not compel someone to undergo a bodily invasion such as organ or tissue transplantation for the benefit of another, how can society view pregnant women refusing treatment any different?"<sup>244</sup>

Another line of arguments has developed from the rescue doctrine or bad samaritan principle of tort law.<sup>245</sup> The rule is that there is no duty in tort to rescue another from risk of injury or death. It is the "common-law principle that an individual is not ordinarily obligated to volunteer aid to another who is in need of assistance, even if the failure to act proves fatal to the imperiled person and the aid necessary to avert the tragic outcome would have involved little inconvenience for the potential rescuer."<sup>246</sup> Those who cite the rescue doctrine in support of maternal rights refer to the general rule as an example of "the importance of freedom of choice."<sup>247</sup> Those who cite the rescue doctrine in support of maternal duties concentrate on its exceptions and limitations.<sup>248</sup>

The *Roe* balancing test may have a variety of doctrinal reference points. However, it remains a construct of conflict in which one set of interests will predictably lose. And it remains a test in which interests are weighted by the preferences of those describing the balancing process. As the cases above demonstrate, those doing the balancing are doctors and judges enmeshed in a culture where the wisdom they receive about good motherhood excludes the experiences of poor women, particularly women of color.

### (B) *Applying the Weighted Balancing Test: Intrusive Fetal Therapy*

Many types of fetal therapy are considered experimental.<sup>249</sup> Nevertheless, innovative procedures present another point of maternal-fetal conflict and

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<sup>243</sup> 226 N.W.2d 180 (Wis. 1975) (The Wisconsin Supreme Court refused to authorize a kidney transplant from an institutionalized mental patient to a sister.).

<sup>244</sup> Nelson, *supra* note 145, at 755; see also Gallagher, *supra* note 177, at 23-24, 26-28 (distinguishing *Strunk and Hart*). "The *Pescinski* decision continues to stand for refusal to countenance nonconsensual bodily invasions for the sake of another." *Id.* at 28.

<sup>245</sup> Compare this line of argument to that of Donald Regan, *Rewriting Roe v. Wade*, 77 MICH. L. REV. 1569 (1979) (Regan argues that if we forbid abortion, we compel a pregnant woman to be a good samaritan. This would violate equal protection because the law burdens other potential samaritans with duties in lesser ways, although there are better reasons to burden them.).

<sup>246</sup> Nelson, *supra* note 145, at 753.

<sup>247</sup> *Id.*

<sup>248</sup> Mathieu, *supra* note 241, at 48.

<sup>249</sup> ELIAS & ANNAS, *supra* note 162, at 252. Federal Regulations impose requirements on methodology, selection procedure, and informed consent for experiments involving human fetuses. 45 C.F.R. § 46, 201-11 (1991). These regulations apply to institutions and researchers that receive federal funds. Many states also have legislated restrictions on fetal research. Most of the state statutes allow therapeutic fetal experiments. See, e.g., CAL. HEALTH & SAFETY CODE § 25956 (Deering 1984); MASS. ANN. LAWS ch. 112, § 12J

another point of direct regulation of pregnant women. Gene therapy, enzyme replacement therapy, and bone marrow transplantation have been suggested as ways to correct fetal defects.<sup>250</sup> Hydrocephaly and urinary tract obstructions have been treated by fetal surgery.<sup>251</sup> Scientists have proposed surgical procedures that could correct congenital diaphragmatic hernias.<sup>252</sup> Surgery on the fetus, however, also requires surgery on the pregnant woman. Since surgery poses risk to the fetus and to the woman, violates religious beliefs, or may be undesirable for other reasons, some women will refuse to consent. As the preceding paragraphs indicate, references to abortion and contraceptive cases, to informed consent cases, and to bad samaritan cases have led to a variety of proposals for direct pregnancy regulation with regard to intrusive fetal therapies.

Maxwell Stearns would authorize forced in utero therapy when the fetus would die but for the procedure. Yet, following the *Roe* trimester analysis, a court order could only be supported if the fetus is viable.<sup>253</sup> If tests reveal that the fetus has a correctable defect that is not fatal, forced intervention, according to the rescue doctrine, cannot be compelled. This is true even if the fetus is viable.<sup>254</sup>

Deborah Mathieu argues that the rescue doctrine is inapt; she would allow "a woman's limited obligation to prevent serious harm to her future child, even in the early stages of pregnancy." Mathieu gives "receiving inoculations or

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(1983); *but see* IND. CODE ANN. § 35-1-58.5-6 (West 1989); OHIO REV. CODE ANN. § 2919.14 (Baldwin 1987).

<sup>250</sup> See EVE NICHOLS, HUMAN GENE THERAPY 58 (1988).

<sup>251</sup> Frank A. Manning et al., *Catheter Shunts for Fetal Hydrocephrosis and Hydrocephalus*, 315 NEW ENG. J. MED. 336 (1986) (In 1986, 114 reports of fetal surgery from 21 medical centers were reviewed by the International Fetal Surgery Registry. Seventy-three cases involved fetal urinary tract obstructions. Surgery was used to implant catheters that drained urine into the amniotic fluid. The fetal death rate attributable to the procedure was 4.8%. Forty-one cases involved fetal hydrocephalus. Doctors attempted to drain fluid from the dilated ventricles. The fetal death rate was 9.8%); *see* William H. Clewett et al., *A Surgical Approach to the Treatment of Fetal Hydrocephalus*, 306 NEW ENG. J. MED. 1320 (1982); Michael R. Harrison et al., *Fetal Surgery for Congenital Hydronephrosis*, 306 NEW ENG. J. MED. 591 (1982).

<sup>252</sup> Margery W. Shaw, *Conditional Prospective Rights of the Fetus*, 5 J. OF LEGAL MED. 63, 79 n.105 (1984) (citing Harrison, Jester & Ross, *Correction of Congenital Diaphragmatic Hernia in Utero, Part I: The Model: Intra-Thoracic Balloon Produces Fetal Pulmonary Hypoplasia*, 88 SURGERY 174 (1980); *Part II: Simulated Correction Permits Fetal Lung Growth with Survival at Birth*, 88 SURGERY 260 (1980); *Part III: Development of a Successful Surgical Technique Using Abdominoplasty to Avoid Compromise of Umbilical Blood Flow*, 16 J. PEDIATR. SURG. 934 (1981)).

<sup>253</sup> Stearns, *supra* note 232, at 624.

<sup>254</sup> *Id.* at 625.

tablespoons of safe medications" as examples of "minimal sacrifices."<sup>255</sup> Intrusions into the woman's bodily integrity rest on the same principles as *Strunk* and *Hart*, the kidney donation cases. These principles are invoked within the framework on the waiver theory. "[A]fter she has foregone the exercise of her legal right to have an abortion. . . [a] woman may be required to undergo more than minimally invasive therapies to prevent significant harm to the child-to-be, and she may be required to accept significant limitations on her freedom of action in order not to cause harm to the child."<sup>256</sup>

John Robertson would go one step further. "If the parents elect not to abort a child, it is reasonable to anticipate that they would have a duty to the unborn child to employ an available medical procedure that would prevent it from being born in an avoidably unhealthy state,"<sup>257</sup> whether tests reveal risk of defect or risk of death. Robertson would then authorize in utero surgery before viability.

### (C) *The Completely Regulated Woman*

Margery Shaw has probably suggested the most extensive regulatory scheme.<sup>258</sup> She has categorized a vast array of potential legal duties into time periods: before conception,<sup>259</sup> early in pregnancy,<sup>260</sup> during mid-pregnancy,<sup>261</sup> and after viability.<sup>262</sup> Many of these time periods would give rise to indirect state regulation. A child born with a defect may have a cause of action in tort against its mother for breaching these duties. However, Shaw also indicates that direct state regulation might be an appropriate way of enforcing several of these duties.

As an example of a duty beginning before conception, Shaw proposes, "[t]he only suggested remedy [for women born with phenylketonuria] is to return the women to a low phenylalaline diet *before* they become pregnant and rigorously monitor them throughout pregnancy."<sup>263</sup> She would require involuntary prenatal testing in some cases. "If the courts decide to mandate prenatal diagnosis in selected cases where there is a significant risk of a very burdensome disease that would cause the child severe pain and suffering and

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<sup>255</sup> Mathieu, *supra* note 241, at 49.

<sup>256</sup> *Id.*

<sup>257</sup> Robertson, *supra* note 238, at 352.

<sup>258</sup> See Shaw, *supra* note 252.

<sup>259</sup> *Id.* at 81-83.

<sup>260</sup> *Id.* at 83-86.

<sup>261</sup> *Id.* at 86-88.

<sup>262</sup> *Id.* at 88-89.

<sup>263</sup> *Id.* at 85 (citing MATERNAL PKU: PROCEEDINGS OF A CONFERENCE, DHHS PUB. NO. [SHA] 81-5299 (1981)).

early death, there are precedents available.”<sup>264</sup> For women whose amniocentesis indicates that the fetus has such a disease, Shaw prescribes selective abortion. “[I]t could be argued that the fetus should be ‘allowed to die’ if it is suffering a fatal disease.”<sup>265</sup> After viability, “the state could order fetal therapy and choose a method of birth in the interests of the fetus if such intervention posed little or no harm to the mother.”<sup>266</sup> Finally, she proposes fetal abuse statutes that would authorize courts to “compel parents and prospective parents to enter alcohol and drug abuse rehabilitation programs, and, in the extreme, to take ‘custody’ of the fetus to prevent mental and physical harm.”<sup>267</sup>

#### (D) *Women with HIV*

Women who are HIV positive present special and perhaps more extensive possibilities for regulation. According to reports, twenty to sixty percent of infants born of women who have tested positive for HIV are themselves HIV positive.<sup>268</sup> Restrictions may be triggered by attempts to treat the mother, by attempts to treat the fetus in utero, and by attempts to prevent maternal-fetal transmission. Within the analytical framework of the balancing test, each of these situations raises the question of whether treatment can be compelled.

At least three forced treatment scenarios have been suggested. First, researchers have suggested that treating pregnant women with AZT may strengthen the chances of children born HIV positive.<sup>269</sup> However, AZT has adverse effects on some adults; so, treating the fetus with AZT may harm the mother. However, as the lower court decision in *In re A.C.* indicates, the case for subsuming the woman’s interests to that of the state may be more persuasive where the woman’s life expectancy is short. Second, the forced cesarean problem may also arise. According to reports, the AIDS virus can be transmitted during vaginal birth; cesarean delivery would be safer.<sup>270</sup> The argument would be that the risks that cesarean surgery poses to the woman are greatly outweighed by the benefits of an HIV-free child. Third, Shaw’s proposals set out an additional scenario. If her arguments are acted upon, women infected with AIDS could be forced to abort their fetuses in order to prevent “a significant risk of a very burdensome disease.”<sup>271</sup>

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<sup>264</sup> *Id.* at 87.

<sup>265</sup> *Id.*

<sup>266</sup> *Id.* at 88.

<sup>267</sup> *Id.* at 100.

<sup>268</sup> Michael L. Closen & Scott H. Isaacman, *Criminally Pregnant: Are AIDS-Transmission Laws Encouraging Abortion?* 76 A.B.A. J., Dec. 1990, at 77.

<sup>269</sup> *Id.*

<sup>270</sup> Shaw, *supra* note 252, at 68.

<sup>271</sup> *Id.* at 87.

Because of the stigma attached to AIDS, history suggests that women who are HIV positive, particularly poor women and women of color, are more vulnerable to state regulation. The standard explanations for poverty, color, and HIV put blame on the victim. HIV, the story goes, harms innocent others—unborn children and society—by putting their health and pocketbooks at risk. The way to prevent this greater harm is to impose a smaller harm on the pregnant woman.

### iii. *Law and Ideology*

The above-cited proposals would continue the trend toward forced intervention. They also continue two parallel stories. One is the current version of the ideology of motherhood. In the 1990s, we can laugh at the century-old medical theory of “prenatal impressions.” According to this theory, a woman must avoid all “shocking, painful or unbeautiful sights,” all intellectual stimulation, angry, or lustful thoughts, and also her husband’s alcohol or tobacco-tainted breath in order to prevent her baby from being deformed or stunted in the womb.<sup>272</sup> We know better now. But the premise behind the prenatal impressions theory is the same as the premise behind current and proposed regulation of pregnant women: Women are childbearers, first and foremost. As such, their lives can be restricted in extraordinary ways. The ideology has established the premise of subordination; it leaves only the medical facts in dispute. If we accept, as did nineteenth century society, that the brain and the fetus competed for energy and phosphates so that a pregnant woman’s mental efforts could deprive the fetus of nutrients, then mental activity can be discouraged by preventing access to higher education.<sup>273</sup> If we accept, as we did in the mid-twentieth century, that weight gain will harm the developing child, then pregnant women can be ordered to diet.<sup>274</sup> If we accept that Ms. Madyun’s doctor may choose the principle of physician control rather than patient choice because it is medically safer, then a pregnant woman can be

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<sup>272</sup> EHRENREICH & ENGLISH, *supra* note 178, at 111; WERTZ & WERTZ, *supra* note 142, at 22. (The Colonial, puritan-influenced version of the theory was that “[t]he abnormal child was a ‘sign’ from God before the whole community, indicating the parent’s spiritual [failure].”).

<sup>273</sup> EHRENREICH & ENGLISH, *supra* note 178, at 127; HALLER & HALLER, *supra* note 13, at 60–61; *see also* EDWARD H. CLARKE, *SEX IN EDUCATION, OR A FAIR CHANCE FOR THE GIRLS* (James R. Osgood, 1873. Reprint ed. Arno Press Inc. 1972) (Dr. Edward H. Clarke concluded that higher education would cause women’s uteruses to atrophy.); A.L. Smith, “*Higher Education of Women and Race Suicide*,” *POPULAR SCIENCE MONTHLY*, LXVI, 466, 467 (1905).

<sup>274</sup> WERTZ & WERTZ, *supra* note 142, at 168 (noting that after 1970 research revealed that placing strict weight gain restrictions on pregnant women created a higher risk of low birth weight babies); KRITZINGER, *supra* note 141, at 73.

forced to submit to cesarean delivery. If we accept using experimental in utero surgery to correct a fetal defect, then courts can order surgery against the woman's will. This is the practice of justifying regulation by defining women as the perfecting agents of society<sup>275</sup> and as mere vessels for the next generation.

The second story is both inextricably linked to the old and entirely new. The new and proposed regulation of pregnant women treats women as wombs as a matter of law. Aristotle believed that the male, during intercourse, implanted the fetal form into the female. The female role in reproduction was merely to provide the material.<sup>276</sup> Aristotle was a philosopher. He has been influential as such—but the Greek state never enacted his theory into statutory law. In 1870, J.L. Holbrook wrote, it was “as if the Almighty, in creating the female sex, had taken the uterus and built up a woman around it.”<sup>277</sup> J.L. Holbrook was a doctor. He may have patronized his women patients, and as a professor he may have influenced his students to do the same, but he never issued a court order. In 1981, the state of Georgia took temporary custody of the fetus carried by Jessie Mae Jefferson. It was so ordered by the Georgia Supreme Court. The second story is the regulatory scheme.

Although the scope of the proposed regulatory scheme varies, the proposals are all premised on the idea that maternal interests must be weighed against fetal ones. Balancing tests all imply that one set of interests can be subordinated to the other. Here, consistent with cultural practice and with legal precedent, the interests of the woman are subordinated to those of another—the fetus. The balancing test says that preventing harm to the fetus justifies restrictions on the woman's decisional autonomy and invasions of her bodily integrity. In the case of proposed preconception duties, the woman's rights would be subordinated to a nonexistent being. The potential for grave harm to the might-be fetus, according to this argument, outweighs the woman's liberty interests.

The balancing test also expresses the corollary notion that regulation of women as childbearers will yield positive results for the rest of society. For one thing, it saves money. Prenatal care and therapy cost less than treating children born with defects.<sup>278</sup> It also produces more money. Children born without defects will presumably have a better chance at being productive members of society. Another good is that forcible therapy preserves the

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<sup>275</sup> HALLER & HALLER, *supra* note 13, at 80.

<sup>276</sup> NANCY TUANA, *THE WEAKER SEED: THE SEXIST BIAS OF REPRODUCTIVE THEORY IN FEMINISM AND SCIENCE* 147, 150 (1989).

<sup>277</sup> EHRENREICH & ENGLISH, *supra* note 178, at 120.

<sup>278</sup> For example, the cost of treating a child born with cystic fibrosis as of 1990 is approximately \$27,000 per year, depending on the amount of care required and the severity of attendant problems. Telephone interview with Dr. Stacey Fitzsimmons, epidemiologist, Cystic Fibrosis Foundation.

integrity of the medical profession.<sup>279</sup> It allows doctors to do what they think is best. It also allows them to forestall the legal liability posed by fetal defect or injury.<sup>280</sup> And forcible therapy allows us to put costly advances in science and technology to use, so that we can justify our investment. Technology has a sort of momentum of its own.

In short, for the sake of the next generation, and for that of society as a whole, the state can regulate women as childbearers. If cultural practice remains consistent, that regulation will continue to fall disproportionately on poor women of color. This prediction is based not only on precedent, but also on common sense. Enforcing the regulatory scheme requires monitoring and reporting.<sup>281</sup> Women using public health facilities and public monies are subject to that monitoring and are more likely to be reported to authorities.<sup>282</sup> It is poor women of color who are most likely to have contact with government agencies and use public hospitals.

Poor women of color are reported at disproportionately higher rates for drug use.<sup>283</sup> It seems logical to conclude that poor women of color will be reported for other behavior at disproportionately higher rates. Private physicians who generally treat white middle- and upper-class women, on the other hand, are not likely to oppose their patients, whose continued patronage they want to preserve.<sup>284</sup> The doctors are more likely to respect these patients as individuals.<sup>285</sup>

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<sup>279</sup> See Bowes & Selgestad, *supra* note 147; Kolder, *supra* note 159; Leiberman, *supra* note 146, at 515. Note that the individual's right to die is weighed against four state interests, including the integrity of the medical profession.

<sup>280</sup> See Bowes & Selgestad, *supra* note 147, at 211 (counsel for the Colorado hospital expressed concern about professional liability when the patient refused to undergo cesarean section, after fetal distress occurred during labor).

<sup>281</sup> See Stearns, *supra* note 232, at 627.

<sup>282</sup> For example, most drug testing occurs in public hospitals. Kary L. Moss, *Legal Issues: Drug Testing of Postpartum Women and Newborns as the Basis for Civil and Criminal Proceedings*, 23 CLEARINGHOUSE REV. 1406, 1407 (March 1990).

<sup>283</sup> Ira J. Chasnoff et al., *The Prevalence of Illicit-Drug or Alcohol Use During Pregnancy and Discrepancies in Mandatory Reporting in Pinellas County, Florida*, 322 NEW ENG. J. MED. 1202-05 (1990) (researchers reported that levels of substance abuse by pregnant women were consistent across racial and economic lines; however, black women were reported to public health authorities ten times more often than were white women); Bonnie I. Robin-Vergeer, Note, *The Problem of the Drug-Exposed Newborn: A Return to Principled Intervention*, 42 STAN. L. REV. 745, 753, 782 (1989-90).

<sup>284</sup> Roberts, *supra* note 104, at 1433.

<sup>285</sup> *Id.*



## 2. Indirect Regulation of the Pregnant Woman

In this section, there are fewer specific historical comparisons to make. Nor are the interventions medical, although medical knowledge about fetal development often serves as evidence in these cases. There is little precedent for restricting women by imposing penalties at law on choices that fail to promote fetal interests. But, the indirect regulations do continue the cultural practice of requiring self-sacrifice by punishing "unnatural" maternal selfishness as defined by the ideology of motherhood. The parallel stories continue. As the fetus gains recognition as a person, the construct of conflict expands. This story is accompanied by the old one, the subordination of women. In the indirect portion of the regulatory scheme, this story is told primarily in terms of tort liability, criminal prosecution, and findings of child neglect based on conduct during pregnancy.

More particular to the indirect regulatory scheme is that it highlights the aspect of the motherhood ideology raised by the criminalization of prostitution and by sterilization abuse. That is, women are not only responsible for maintaining and perpetuating social order, they are also to blame when disorder prevails. Society expresses its fear of disorder by regulating women as bad mothers.

### a. Tort Liability: The Reasonable Pregnant Woman

The Parental Immunity Doctrine emerged in the late nineteenth century,<sup>286</sup> but has since broken down.<sup>287</sup> Some jurisdictions have abolished it entirely;<sup>288</sup> others have limited it so that children can sue their parents for injuries caused after birth.<sup>289</sup> Parents have long been able to recover for third party acts that harmed or killed a fetus.<sup>290</sup> Since 1946, courts have recognized tort actions

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<sup>286</sup> *Foldi v. Jeffries*, 461 A.2d 1145 (N.J. 1983) (summarizing the history of the parental immunity doctrine in the United States). "The English common law did not recognize the doctrine of parental immunity. The doctrine emerged later in this country in three state court decisions, sometimes referred to as 'The Great Trilogy.'" *Id.* at 1147. *See also* *Hewellette v. George*, 9 So. 885 (Miss. 1891); *McKelvey v. McKelvey*, 77 S.W. 664 (Tenn. 1903), *overruled by*, *Davis v. Davis*, 657 S.W.2d 753 (Tenn. 1983); *Roller v. Roller*, 79 P. 788 (Wash. 1905), *overruled by*, *Borst v. Borst*, 251 P.2d 149 (Wash. 1952).

<sup>287</sup> *See Goller v. White*, 122 N.W.2d 193, 198 (Wis. 1963) (This was the first case to limit parental immunity. The Wisconsin court maintained immunity for acts constituting an exercise of parental authority or parental discretion in providing care.).

<sup>288</sup> *See, e.g., Gibson v. Gibson*, 479 P.2d 648 (Cal. 1971); *Gelbman v. Gelbman*, 245 N.E.2d 192 (N.Y. 1969); *Falco v. Pados*, 282 A.2d 351 (Pa. 1971).

<sup>289</sup> *See, e.g., Foldi v. Jeffries*, 461 A.2d 1145 (N.J. 1983).

<sup>290</sup> There is a split in authority over the issue of whether to recognize a wrongful death action for a stillborn viable fetus. W.P. KEETON ET AL., PROSSER AND KEETON ON THE LAW

brought by children for pre-birth injuries caused by third persons.<sup>291</sup> More recently, children have been able to recover for third party acts that resulted in their "wrongful life."<sup>292</sup> Now it is becoming likely that a child could recover against her parents for harms caused by conception or during pregnancy.

In *Grodin v. Grodin*,<sup>293</sup> Randy Grodin sued his mother, Roberta Grodin, for taking Tetracycline during pregnancy. Because his mother took this antibiotic while pregnant with him, Randy Grodin's teeth were discolored. The trial court granted summary judgment for Ms. Grodin. However, the Michigan Court of Appeals reversed and remanded so that the reasonableness of taking Tetracycline for the mother's health in light of the risk to the unborn child could be determined. The court said, "[a] woman's decision to continue taking drugs during pregnancy is an exercise of her discretion. The focal question is whether the decision reached by a woman in a particular case was a 'reasonable exercise of parental discretion.'"<sup>294</sup> A woman can choose, then, but she had better not choose wrongly.

A child was also the plaintiff in *Curlender v. Bio-Science Laboratories*.<sup>295</sup> There, the California Court of Appeals held that a child born with Tay-Sachs

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OF TORTS § 55, at 368-69 (5th ed. 1984). However, even in jurisdictions that do not recognize wrongful fetal death as actionable, courts have been willing to compensate parents for harm caused by fetal death or injury. *Modaber v. Kelley*, 348 S.E.2d 233 (Va. 1986) (upholding award of \$750,000 for physical and emotional suffering caused by physicians negligent treatment of toxemic mother and unborn child); *Craig v. IMT Ins. Co.*, 407 N.W.2d 584 (Iowa 1987) (permitting recovery for loss of consortium for death of unborn but viable child killed in automobile accident).

<sup>291</sup> *Bonbrest v. Kotz*, 65 F. Supp. 138 (D.D.C. 1946) (the first case to allow recovery for prenatal injury); see Honorable Tom Rickhoff & Curtis L. Cukjan, *Protecting the Fetus from Maternal Drug & Alcohol Abuse: A Proposal for Texas*, 21 ST. MARY'S L.J. 259, 277-81 (1989); see also Karen Crockett & Miriam Hyman, Note, *Live Birth: A Condition Precedent to Recognition of Rights*, 4 HOFSTRA L. REV. 805, 825 (1976) ("Since the purpose of recovery in cases of prenatal injuries is to provide compensation for a child burdened with life-long infirmities, courts do allow recovery for prenatal injury if there is subsequently a live-birth . . . . Recovery is not . . . a recognition that the prenatal child has legal rights.").

<sup>292</sup> *Turpin v. Sortini*, 643 P.2d 954 (Cal. 1982) (child born with hereditary deafness granted recovery for special damages from the doctor who failed to inform parents that condition of plaintiff's elder sister was hereditary); *Curlender v. Bio-Science Lab.*, 165 Cal. Rptr. 477 (Ct. App. 1980) (child born with Tay-Sachs may recover from doctors who failed to inform parents that they were carriers of Tay-Sachs disease); *Harbeson v. Parke-Davis, Inc.*, 656 P.2d 483 (Wash. 1983) (granting child recovery for extraordinary expenses incurred during her lifetime due to congenital defects that arose when Air Force doctors failed to inform parents of dangers of Dilantin, a drug prescribed for the mother's epilepsy).

<sup>293</sup> 301 N.W.2d 869 (Mich. Ct. App. 1980).

<sup>294</sup> *Id.* at 870-71.

<sup>295</sup> 165 Cal. Rptr. 477 (Ct. App. 1980).

disease had a cause of action against two laboratories that had failed to identify the parents as carriers of the disease. In dicta, the court said:

If a case arose where, despite due care by the medical profession in transmitting the necessary warnings, parents made a conscious choice to proceed with a pregnancy, with full knowledge that a seriously impaired infant would be born, that conscious choice would provide an intervening act of proximate cause to preclude liability insofar as defendants other than the parents were concerned. Under such circumstances, we see no sound public policy which should protect those parents from being answerable for the pain, suffering and misery which they have wrought upon their offspring.<sup>296</sup>

Tort liability would give the notion of maternal-fetal conflict a new meaning. According to the Illinois Supreme Court, if maternal liability for prenatal injuries were recognized, "mother and child would be legal adversaries from the moment of conception until birth."<sup>297</sup> A fetal right in tort would make pregnant women the legal, as well as the moral, insurers of the next generation's health and happiness.

This is, in essence, what Shaw proposes—broad-based tort liability for maternal failures that result in defect and suffering.<sup>298</sup> She describes three general sources of actionable harm. The first is posed by environmental teratogens and embryotoxins.<sup>299</sup> Failure to seek treatment for illness, exposing oneself to certain chemicals and occupational hazards, and taking certain prescription drugs may be actionable. The second source of harm is the woman's lifestyle decisions.<sup>300</sup> Women addicted to alcohol or drugs whose children are born with fetal alcohol syndrome or fetal narcotic addiction would be liable. The third is genetic defects, arising from either environmentally-

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<sup>296</sup> *Id.* at 488. But note that in response to *Curlender*, the California legislature enacted CAL. CIV. CODE § 43.6 (West 1981):

(a) No cause of action arises against a parent of a child based upon the claim that the child should not have been conceived or, if conceived, should not have been allowed to have been born alive.

(b) The failure or refusal of a parent to prevent the live birth of his or her child shall not be a defense in any action against a third party, nor shall the failure or refusal be considered in awarding damages in any such action.

(c) As used in this section, "conceived" means the fertilization of a human ovum by a human sperm.

<sup>297</sup> *Stallman v. Youngquist*, 531 N.E.2d 355, 359 (Ill. 1988).

<sup>298</sup> *Shaw*, *supra* note 252, at 90-98. But see ELIAS & ANNAS, *supra* note 162, at 260-61 (criticizing the use of tort actions).

<sup>299</sup> *Shaw*, *supra* note 252, at 66-73.

<sup>300</sup> *Id.* at 73-75.

caused mutagens or from existing deleterious genes.<sup>301</sup> Failure to seek genetic testing and counseling, and failure to use contraceptives or to abort a defective fetus, could be actionable.

Some women, in other words, should not become mothers at all. Professor Shaw's message echoes Justice Holmes' baleful commentary in *Buck v. Bell*—"Three generations of imbeciles are enough."<sup>302</sup> It is not simply a concern for sparing children from painful lives, nor is it simply preventive medicine. It is, rather, a way of designating certain persons as dangerous agents, of treating certain pregnancies as controlled substances, and of saying that humanity at its fullest is not desirable.

More generally, actions giving rise to tort liability become a part of the profile of a bad mother. A woman who becomes pregnant must act solely as a good mother. More accurately, a woman who becomes pregnant must make all decisions with regard to her womb. Since Shaw proposes pre-conception negligence,<sup>303</sup> a woman who *might* become pregnant must act first for her womb. Any act or omission not made with the fetus or would-be fetus foremost in a woman's mind would expose her to liability. Thus, maternal tort liability to fetuses becomes a more oppressive version of the nineteenth century ideal of a pregnant woman as a "soul gardener."<sup>304</sup> The idea then was that it was the pregnant woman's moral duty to provide "good soil" for the child during its prenatal life. "[T]he pregnant woman was to direct herself to the goal of creating the best possible child."<sup>305</sup> Today, if maternal liability in tort expands, it could be the state who directs the woman.

#### b. *Criminal Transmission of HIV*

The Institute of Medicine has identified transmission from mother to fetus during gestation, birth, or breastfeeding, as one of the three major means of infection.<sup>306</sup> It is not clear if they intended it,<sup>307</sup> but Arkansas,<sup>308</sup> Illinois,<sup>309</sup>

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<sup>301</sup> *Id.* at 75-78.

<sup>302</sup> *Buck v. Bell*, 274 U.S. 200, 207 (1927).

<sup>303</sup> Shaw, *supra* note 252, at 91-95.

<sup>304</sup> HALLER & HALLER, *supra* note 13, at 133.

<sup>305</sup> *Id.*

<sup>306</sup> INSTITUTE OF MEDICINE, NATIONAL ACADEMY OF SCIENCE, CONFRONTING AIDS: UPDATE 1988 43 (1988); *see also* Donald P. Francis, MD, DSC & James Chinn, MD, MPH, *The Prevention of Acquired Immunodeficiency Syndrome in the United States*, 257 JAMA 1357, 1358-59 (Mar. 13, 1987). The other two major means of transmitting AIDS are through sexual contact where semen or vaginal secretions are exchanged and through the sharing of unsterilized needles by intravenous drug users.

<sup>307</sup> Closen & Isaacman, *supra* note 268, at 77.

<sup>308</sup> ARK. CODE ANN., § 5-14-123 (Michie Supp. 3, 1991).

<sup>309</sup> ILL. REV. STAT. ch. 38, ¶ 12-16.2 (Supp. 1992).

Louisiana,<sup>310</sup> and Missouri<sup>311</sup> have enacted statutes that make it illegal for HIV-infected women to have children. These statutes criminalize the knowing transmission of HIV. The Illinois statute provides, “[a] person commits a criminal transmission of HIV when he or she, knowing that he or she is infected with HIV, engages in intimate contact with another.”<sup>312</sup> The statute defines “intimate contact” as “the exposure of one person to a bodily fluid of another person in a manner that could result in the transmission of HIV.”<sup>313</sup> Studies show that twenty to sixty percent of children born to HIV positive women are HIV-infected.<sup>314</sup> If a woman knows she is HIV positive, carries her pregnancy to term, and gives birth to an HIV-infected child, she may well have committed a felony.

It has been pointed out that HIV criminal transmission laws encourage abortion and “outlaw motherhood.”<sup>315</sup> If prosecutors were to use these laws against women who give birth to HIV-infected babies, the criminalization of motherhood under these statutes would not be an isolated event. In the next subsection, I describe the trend toward penalizing women for transmitting drugs or alcohol to their fetuses. The prosecution of women with HIV would not be unlike the prosecution of addicted women who have babies. AIDS, like

<sup>310</sup> LA. REV. STAT. ANN. § 14:43.5 (West Supp. 1992).

<sup>311</sup> MO. ANN. STAT. § 191.677(1)(2) (Vernon Supp. 1992) (“It shall be unlawful for any individual knowingly infected with HIV to . . . [d]eliberately create a grave and unjustifiable risk of infecting another with HIV through sexual or other contact when an individual knows that he is creating that risk.”).

<sup>312</sup> ILL. REV. STAT., ch. 38 ¶ 12-16.2 (Supp. 1992).

<sup>313</sup> *Id.* ¶ 12-16.2(b).

<sup>314</sup> INSTITUTE OF MEDICINE, NATIONAL ACADEMY OF SCIENCE, *supra* note 306, at 52; REPORT OF THE PRESIDENTIAL COMMISSION ON THE HUMAN IMMUNODEFICIENCY VIRUS, 12 (June, 1988); Peter A. Selwyn, MD, MPH et al., *Knowledge of HIV Antibody Status and Decisions to Continue or Terminate Pregnancy Among Intravenous Drug Users*, 261 JAMA 3567 (1989).

<sup>315</sup> Closen & Isaacman, *supra* note 268. Compare the approach under federal family planning policy, which promotes education and counseling:

All Title X clinics must offer, at a minimum, education on HIV infection and AIDS, counseling on risks and infection prevention, and referral services. Other services such as risk assessment, counseling about testing and administering tests may also be provided. If other resources are unavailable, Title X funds may be used to support these services. Of particular importance is the role of Title X projects in offering effective methods of family planning to sexually active HIV-infected women who run a high risk of perinatal transmission in pregnancy and who run a significant risk of transmitting HIV to other sexual partners.

DEPT. OF HEALTH & HUMAN SERVICES, MEMORANDUM FROM NABERS CABINESS, OFFICE OF POPULATION AFFAIRS PROGRAM INSTRUCTION SERIES OPA-87-4: AIDS EDUCATION, COUNSELING AND TESTING IN TITLE X (1987).

substance abuse, is considered a major social problem, triggering the same type of sympathy for infants born infected. The same concern for the public interests predominates in both issues. Pregnant women are the designated transmitters in both situations—rendering them prime suspects for the label “bad mothers” and for legal penalties. Good mothers transmit morality and social order by their maternal nature; they transmit good genes by their physical capacity to bear children. Bad mothers transmit bad values and disorder; they transmit HIV and harmful substances by their physical capacity to bear children. Good mothers have healthy children. Bad mothers have sick children who will be burdens on society.

*c. Criminal Prosecutions of Pregnant Women Who Are Addicts*

In the past few years, women have been prosecuted for a variety of crimes that all amount to the same offense: behavior during pregnancy that creates risk or harm to the fetus. The criminal prosecution of women for acts against fetuses is the strongest form of reinforcing the ideology. The message that bad mothers should be punished is express when criminal law is utilized.

The widely publicized story of Jennifer Johnson illustrates this point.<sup>316</sup> Jennifer Johnson, an addict, took cocaine during her two pregnancies. When her son was born on October 3, 1987, he tested positive for benzoylecgonine, a cocaine metabolite. Jennifer Johnson admitted using cocaine the previous night. During her second pregnancy, Ms. Johnson suffered a crack overdose. A month later, while in labor, she used rock cocaine. She gave birth to a daughter. Both births were normal, with no complications nor signs of fetal distress.<sup>317</sup>

Following the birth of her daughter, Jennifer Johnson was prosecuted. According to the complaint and to the court, Ms. Johnson was guilty of delivering a controlled substance to a minor. Infants are persons, under the statute, but fetuses are not. The prosecutor's theory was that Ms. Johnson had delivered cocaine to her children between the time the child emerged from the birth canal and the moment the doctor severed the umbilical cord.<sup>318</sup> Medical experts testified that it is theoretically possible that a woman could smoke cocaine at 10:00 p.m. and that, during the next afternoon, the metabolized derivatives could diffuse to the placenta and pass to the baby through the umbilical cord during the thirty to ninety seconds after birth and before the umbilical cord was cut.<sup>319</sup> Experts also testified, however, that cocaine has a half-life of one hour, that blood flow through the umbilical cord is restricted

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<sup>316</sup> *Johnson v. State*, 578 So. 2d 419 (Fla. Dist. Ct. App. 1991).

<sup>317</sup> *Id.* at 421–22 (Sharp, J., dissenting).

<sup>318</sup> *Id.* at 419.

<sup>319</sup> *Id.*

during childbirth, and that it is impossible to tell whether metabolites passed before or after birth.<sup>320</sup> In July 1989, the court sentenced her to 15 years of probation.<sup>321</sup> She was ordered to submit to random drug testing for the first year and follow a supervised program during future pregnancies.<sup>322</sup> The Supreme Court of Florida finally overturned the conviction on July 23, 1992.<sup>323</sup>

The lower court decisions can be criticized on a number of legal grounds.<sup>324</sup> But understanding the case as an elaboration upon the ideology of motherhood is important. The easier point to be made is that the lower Florida courts identified Jennifer Johnson as a bad mother and were willing to regulate her as such for the next fifteen years. This point needs elaboration; it is more complex than it appears. It is not simply that the prosecutor's theory was absurd or that the use of criminal law to address the harms of addiction is inappropriate. Rather, this decision sends a complicated message about how women's roles are defined. The women most likely to be labeled bad mothers are those whose behavior implicates points of social disorder. One can identify a society's current concerns by reviewing its current regulatory scheme. In a society's direct regulations, one can detect influences from the pro-life movement<sup>325</sup> and the growing faith in biological determinism. Biological

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<sup>320</sup> *Id.* at 422.

<sup>321</sup> Tamar Lewin, *Drug Verdict Over Infants is Voided*, N.Y. TIMES, July 24, 1992, at B6.

<sup>322</sup> *Id.*

<sup>323</sup> *Johnson v. State*, 602 So. 2d 1288 (Fla. 1992).

<sup>324</sup> In her dissenting opinion, Judge Sharp disputed the applicability of the criminal statute to the birthing process, and argued that even if the statute was intended to apply, there was no medical testimony to support the trial court's finding that "delivery" of controlled substances occurred during the birth. *Id.* at 421-22. Nor was there any evidence that Johnson timed her dosage of cocaine so as to be able to transmit some small amount after her child's birth. *Id.* at 421. Judge Sharp noted that prosecuting women for using drugs and "delivering" them to their newborns is an ineffective response to the problem of substance abuse by pregnant women. "Rather than face the possibility of prosecution, pregnant women who are substance abusers may simply avoid prenatal or medical care for fear of being detected." *Id.* at 426. "Prosecution of pregnant women for engaging in activities harmful to their fetuses or newborns may also unwittingly increase the incidence of abortion." *Id.* at 426-27 (citations omitted). The Florida Supreme Court's opinion cites Judge Sharp's dissent extensively.

See also Jacqueline Berrien, *Pregnancy and Drug Use: The Dangerous and Unequal Use of Punitive Measures*, 2 YALE J.L. & FEMINISM 239 (1990); Kary Moss, *Substance Abuse During Pregnancy*, 13 HARV. WOMEN'S L.J. 278, 284-92 (1990); Roberts, *supra* note 104; McNulty, Note, *supra* note 140; Note, *Maternal Rights and Fetal Wrongs: The Case Against the Criminalization of "Fetal Abuse,"* 101 HARV. L. REV. 994 (1988).

<sup>325</sup> Fetal rights proponents include those who take the pro-life position in the abortion debate. Fetal rights proponents take *Roe v. Wade* out of the abortion context to advocate

determinism is most apparent in the scheme of indirect regulations.<sup>326</sup> The concern that dominates the criminal prosecutions has been raised by the "War on Drugs."<sup>327</sup> The message that these prosecutions convey is not simply that women who use drugs or alcohol are bad mothers, but, more importantly, that it is at least partly the failure of the institution of motherhood that has led to this disorder.

One response to this perceived failure is to call for reinforcement of the institution. Thus, while advances in medicine have encouraged us to comprehend the fetus as an entity separate from the pregnant woman, the fear of failure adds the regulation of pregnant women to the idea of fetal personhood. In other words, one answer to the call for reinforcements is increased medical intervention; another is erecting a civil standard of reasonable pregnancy behavior; and yet another is the criminal prosecution of pregnant women.<sup>328</sup>

The *Johnson* case is not unique. More than 160 women have been arrested in twenty-four states for drug use during pregnancy. Most of them have pleaded guilty. Of those who contested, none have been convicted.<sup>329</sup> In Michigan, Muskegon County Prosecutor Tony Tague filed a two-count felony complaint against Kimberly Hardy for using cocaine during pregnancy.<sup>330</sup> Ms.

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recognition of "potential life" in a way that overrides the woman's interests. See Gallagher, *supra* note 177, at 15, 31, 41-42.

The forced prenatal treatment cases and proposals reflect, in part, a belief that the state may not only protect fetal life, but can guarantee that the fetus be born whole and sound. If the state takes this to its extreme, as Professor Shaw does, a woman who gives birth to an unhealthy or seriously defective infant has violated moral and legal duties. See *supra* notes 298-305 and accompanying text.

<sup>326</sup> The tort cases and the laws punishing women for alcohol and drug use during pregnancy do not express concern for protecting the life of the fetus per se, but for maximizing the fetus's chances for social, economic, and emotional success by preventing defects that would threaten those chances, and for protecting society from the costs of social, economic, and emotional failures.

<sup>327</sup> The "War on Drugs" reflects the Reagan-Bush efforts to address the growing drug crisis. From 1988, the Bush administration allocated over \$10 billion annually towards curbing the drug problem. Under the direction of federal "drug czar" William Bennett and his successor, former Florida Governor Bob Martinez, approximately 70% of this allocation was earmarked for law enforcement, prosecution of drug dealers and users, and building new prisons. The major emphasis of the national drug strategy has been on reducing supply, rather than on programs directed toward education, prevention, and treatment.

<sup>328</sup> See Berrien, *supra* note 324; Dawn Johnsen, *From Driving to Drugs: Governmental Regulation of Pregnant Women's Lives After Webster*, 138 U. PA. L. REV. 179 (1989); Doretta Massardo McGinnis, *Prosecution of Mothers of Drug-Exposed Babies: Constitutional and Criminal Theory*, 139 U. PA. L. REV. 505 (1990); Moss, *supra* note 282; Roberts, *supra* note 104; Note, *Maternal Rights*, *supra* note 324.

<sup>329</sup> Lewin, *supra* note 321, at B6.

<sup>330</sup> *People v. Hardy*, 469 N.W.2d 50 (Mich. Ct. App. 1991).



Hardy, a Black woman and an addict, had smoked crack cocaine less than thirteen hours before giving birth. Her son, Arianis,<sup>331</sup> exhibited signs of drug ingestion at birth—small size for gestational age of 7-1/2 months, distended abdomen, and spitting up. Tague charged her with delivery of less than fifty grams of a mixture containing cocaine. He used the umbilical cord delivery theory.<sup>332</sup> In addition, he charged Kimberly Hardy with second-degree child abuse. He alleged that by ingesting cocaine while pregnant, she caused serious physical harm to her minor child. He argued, without supporting authority, that a fetus is a “person” because it is a “legal entity.”<sup>333</sup> Both felony counts were quashed. In fact, many of these charges are being dismissed and the convictions overturned.<sup>334</sup> These statutes, according to the courts, are simply not intended to regulate pregnant women. However, the concept of fetal personhood has been added to the ideology, and attempts to add it to the legal construct persist. As of 1987, there were at least fifty other “fetal abuse” cases in twenty jurisdictions.<sup>335</sup>

In terms of court victories, prosecutors are also having slight success under criminal child neglect and endangerment statutes.<sup>336</sup> In these cases, the theory

<sup>331</sup> Andrea Stone, *Mother Cleared of Giving Cocaine to Child at Birth*, U.S.A. TODAY, April 4, 1991, at 2A. He is now healthy.

<sup>332</sup> See *People v. Bremer*, No. 90-32227-FH (Mich. Cir. Ct., Jan. 31, 1991) (When newborns tested positive for cocaine metabolites, the mother was charged with delivery of cocaine. The Circuit Court held that the Michigan Legislature never intended the delivery statute to apply in this situation. The court also rejected the prosecutor's contention that charging women for delivering illegal drugs to newborns provides a strong deterrent to drug use and prompts women to seek drug treatment. Note that the court in *Johnson* cited this case.); *State v. Gray*, No. L-89-239, 1990 WL 125695 (Ohio Ct. App. Aug. 31, 1990) (“To construe the statute in this manner would mean that every expectant woman who ingested a substance with the potential for harm to her child, e.g., alcohol or nicotine, would be criminally liable under R.C. 2919.22(A), [the child endangering statute]. We do not believe such a result was intended by the General Assembly.”); *Commonwealth v. Pellegrini*, No. 87970 (Mass. Sup. Ct., Oct. 15, 1990).

<sup>333</sup> *Hardy*, 469 N.W.2d at 53 (Reilly, J., concurring). Ms. Hardy was charged under a statute that provides, “a person shall not manufacture, deliver, or possess with intent to deliver a controlled substance . . .” MICH. COMP. LAWS ANN. § 333.7401(1) (West 1980). “Delivery” is defined as the transfer of a controlled substance from one person to another. *Id.* § 333.7105(1). “Person” is defined as “an individual, partnership, cooperative association, private corporation, personal representative, . . . or any other legal entity.” *Id.* §§ 333.7109(1), .1106.

<sup>334</sup> See Jan Hoffman, *Pregnant, Addicted—and Guilty?*, N.Y. TIMES, Aug. 19, 1990, § 6 (Magazine), at 32, 35; Stone, *supra* note 331.

<sup>335</sup> Hoffman, *supra* note 334.

<sup>336</sup> *People v. Stewart*, No. M508197 (San Diego, Cal. Mun. Ct. Feb. 23, 1987) (Pamela Rae Stewart was charged with child abuse under California Penal Code § 270 for willfully omitting to furnish medical services. It was alleged that she abused the fetus by using amphetamines during pregnancy, by engaging in sexual intercourse, and by failing to

focuses on the idea that a fetus is a person rather than that a mother used the umbilical cord voluntarily to deliver drugs to the newborn.<sup>337</sup> Although the conviction rate is low, and although these cases have provoked the same type of criticism as the *Johnson* and *Hardy* cases,<sup>338</sup> criminal prosecutions have succeeded in hardening the assumption of a maternal-fetal conflict. The prosecutor and the attendant publicity have built sympathy and support for infants born with fetal alcohol syndrome or fetal drug addiction, but have also cast these infants as burdens placed on society by selfish, destructive mothers.<sup>339</sup> Very few, on the other hand, have questioned the use of prosecutorial discretion in pursuing these cases.<sup>340</sup>

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seek medical attention when bleeding began, all despite the doctor's advice. The child, born brain damaged, died a few weeks after birth. The court dismissed the charges because the statute was intended to enforce child support arrangements, not to penalize certain behavior during pregnancy.); *State v. Gray*, No. L-89-239, 1990 WL 125695 (Ohio Ct. App. Aug. 31, 1990) (The charges under the criminal child endangerment statute were dismissed. The court affirmed the trial court's determination that the statute did not create a duty of care to a fetus.); *State v. Gethers*, No. 894454 CF10A (Cir. Ct., Broward Co., Fla. 1989) (The court dismissed a criminal child abuse charge based upon alleged maternal cocaine use and delivery of a child who tested positive for cocaine. A "person" within the meaning of the statute does not include a fetus.); *Reyes v. Superior Court*, 141 Cal. Rptr. 912 (Ct. App. 1977) (Margaret Velasquez continued to take heroin during her pregnancy despite warnings from a public health nurse. She gave birth to twins who suffered withdrawal symptoms. The court held that the statutory definition of "child" did not include a fetus and set aside both counts of felony child endangering.). See Bruce Henderson, *Mothers of Infant Addicts: Does Prosecution Help?*, CHARLOTTE OBSERVER, Aug. 26, 1989, at 1A (Prosecutor charged Candace Woolery with criminal neglect after Woolery gave birth to a baby who tested positive for heroin); Moss, *supra* note 324 (women have also been arrested in Colorado, Connecticut, Illinois, Indiana, Massachusetts, and Michigan).

<sup>337</sup> See also Leiberman et al., *supra* note 146, at 517 (arguing that a woman's decision to refuse medical treatment on behalf of the fetus should be a felony). Leiberman suggests that the woman's refusal to consent is analogous to child abuse.

<sup>338</sup> See Berrien, *supra* note 324, at 239; Laurie Rubenstein, *Prosecuting Maternal Substance Abusers: An Unjustified and Ineffective Policy*, 9 YALE L. & POL'Y REV. 130 (1991); Note, *Maternal Rights*, *supra* note 324, at 1009-12; see also Note, *Regulating Women's Bodies: The Adverse Effect of Fetal Rights Theory on Childbirth Decisions and Women of Color*, 26 HARV. C.R.-C.L. L. REV. 523, 525-29 (1991).

<sup>339</sup> See, e.g., Rickhoff & Cukjan, *supra* note 291, at 286 (describing the issue as a conflict between good and voluntary evil—the right of “children, who are helpless at birth . . . to be born free of health problems caused by the mother's misconduct, to be nurtured, and to be free from abuse at birth” versus the pregnant woman's “right to use drugs and alcohol to the detriment of her fetus”); *People v. Hardy*, 469 N.W.2d 50, 55 (Mich. Ct. App. 1991) (summarizing the prosecutor's argument “that the strong enforcement of our drug laws is the first step in protecting the newborn from the mother's selfish and destructive conduct”).

<sup>340</sup> Dwight L. Greene, *Abusive Prosecutors: Gender, Race & Class Discretion and the Prosecution of Drug-Addicted Mothers*, 39 BUFF. L. REV. 737, 779 (1991).

Other efforts to criminalize bad motherhood have been based on charges of manslaughter.<sup>341</sup> These cases also concerned alcohol or drug use by the pregnant woman. Again, it appears that prosecutors are losing these cases. However, the willingness to penalize women for behavior during pregnancy is the prevailing spirit. Judges, like Wolf, who sentenced Brenda Vaughn to 180 days in jail for fraud after she tested positive for cocaine, and prosecutors, like Tague, are getting help in their efforts<sup>342</sup> to reinforce good motherhood by punishing bad versions of motherhood. It is the legislators who are providing that help.

State and federal legislators have proposed criminal "fetal abuse" bills.<sup>343</sup> These proposed laws describe certain activities during pregnancy as a form of child abuse. Senator Pete Wilson (now Governor) of California introduced the "Child Abuse During Pregnancy Prevention Act of 1989"<sup>344</sup> in the United States Senate. Although unenacted, the bill may yet serve as a model for state laws against substance abuse during pregnancy. The bill defines substance abuse<sup>345</sup> as a form of child abuse and provides for "testing of newborn infants for the effects of maternal substance abuse so that infants addicted or otherwise injured or impaired by the substance abuse of their mothers will be brought to the attention of the proper authorities."<sup>346</sup> Its stated purposes are to prevent

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<sup>341</sup> Patrick Reardon, *Grand Jury Won't Indict Mother in Baby's Death*, CHI. TRIB., May 27, 1989, at 1 (describing failed prosecution of Melanie Green, a black woman, for manslaughter after her child died soon after birth. It was alleged that the child's death was caused by Ms. Green's use of cocaine during pregnancy.).

<sup>342</sup> Some of the judges who refuse to apply these statutes to pregnant women have called upon the legislatures to provide appropriate means of penalizing drug- or alcohol-addicted women who have babies. See *State v. Gray*, No. L-89-239, 1990 WL 125695, at \*6 (Ohio Ct. App. Aug. 31, 1990). But see *Johnson v. State*, 578 So. 2d 419, 426 (Fla. Dist. Ct. App. 1991) ("[p]rosecuting women for using drugs and 'delivering' them to their newborns appears to be the least effective response to this crisis").

<sup>343</sup> See, e.g., H.R. Res. 90, 57th Gen. Sess. (1990 Colo. Laws) (criminalizing child abuse for reasons including abuse of a controlled substance and assisting a pregnant woman in use of a controlled substance); H.R. Res. 1146, Reg. Leg. Sess. (1990 Ga. Laws) (would have criminalized the distribution of a controlled substance to an unborn child); H.R. Res. 90-976, Reg. Sess. (1990 La. Laws) (would make it unlawful to give birth to an infant addicted to heroin or cocaine); UTAH CODE ANN. § 62A-4-511 (1989) (makes the birth of a child with fetal alcohol syndrome a misdemeanor); see also, Note, *When Self Abuse Becomes Child Abuse: The Need for Coercive Prenatal Government Action in Response to the Cocaine Baby Problem*, 11 N. ILL. U.L. REV. 73 (1990).

<sup>344</sup> S. 1444, 101st Cong., 1st Sess. (1989).

<sup>345</sup> "Substance abuse" is defined as "the use of controlled substances . . . the possession or distribution of which is unlawful under such Act, or excessive or injurious ingestion of legal substances, including beverage alcohol." *Id.* § 3(a)(1). Tobacco and caffeine could also trigger this law.

<sup>346</sup> *Id.* § 2(a)(12).

substance abuse by pregnant women by outreach and intervention during early pregnancy and by mandatory rehabilitation of women who give birth to addicted or otherwise impaired infants.<sup>347</sup>

Grants to the states for outreach and education would fund the projects proposed by the bill.<sup>348</sup> To obtain a grant, a state must certify that it is a crime to abuse a child by giving birth to an addicted or impaired infant. The state must also certify that "on a conviction . . . the female so convicted shall be sentenced to a period of three years of mandatory rehabilitation in a custodial setting."<sup>349</sup> The state may provide one exception to this crime. If a woman in the first trimester of her pregnancy "voluntarily submit[s] to rehabilitation for such term and under such conditions as competent medical authorities shall prescribe . . . such female shall not be charged with criminal child abuse if she completes the term and conditions prescribed."<sup>350</sup> Other statutes do not specifically provide for criminal prosecution, but do provide for infant testing and reporting of toxicology screens to the state.<sup>351</sup> If the tests indicate maternal substance abuse, the woman can be prosecuted on this information. Only a few bills or statutes provide immunity to the woman so that women will not be afraid to seek prenatal care.<sup>352</sup>

Efforts to make drug use during pregnancy a substantive crime should be examined for what they do and do not accomplish. Fetal abuse laws or other criminal laws will not help the fetuses of convicted mothers. According to the American Academy of Pediatrics, "[p]unitive measures taken toward pregnant women, such as criminal prosecution and incarceration, have no proven benefits to infant health."<sup>353</sup> In fact, "such involuntary measures are likely to discourage mothers and their infants from receiving the very medical care and social support systems that are crucial to their treatment."<sup>354</sup> Further,

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<sup>347</sup> *Id.* § 2(b).

<sup>348</sup> *Id.* § 3(b).

<sup>349</sup> *Id.* § 3(c)(4)-(5).

<sup>350</sup> *Id.* § 3(c)(5).

<sup>351</sup> MINN. STAT. ANN. § 626.5562 (West 1991); S.B. 657 Maryland (1991), H.B. 1000 Maryland (1991); S.B. 1197, Reg. Sess., Pa. (1991); H.F. 2564 Iowa (1990); WIS. STAT. ANN. § 146.0255 (West 1991); *see also*, FLA. STAT. ANN. §§ 415.503(9)(a)(2), .504 (West Supp. 1989) (requiring doctors to report women who abused drugs during their pregnancies to health authorities and broadening definition of injury to child to include newborn dependency on controlled substances). For results of a study conducted to determine physician compliance with this reporting requirement, *see supra* note 283 and accompanying text.

<sup>352</sup> *See* S.B. No. 1197 Penn. (1991).

<sup>353</sup> Abigail English, *Prenatal Drug Exposure & Pediatric AIDS: New Issues for Children's Attorneys*, 24 CLEARINGHOUSE REV. 452, 454 (1990) (quoting Provisional Comm. on Substance Abuse, Am. Academy of Pediatrics, *Drug Exposed Infants*, PEDIATRICS (Oct. 1990)).

<sup>354</sup> *Id.*

prosecution and incarceration of pregnant women can be directly detrimental to fetal health.<sup>355</sup> Prosecution for drug or alcohol use during pregnancy does seek to deter other women, although, as noted above, this attempt to deter others is not only counterproductive, it is also counterintuitive.<sup>356</sup> As a last-but-not-least note on what the criminalization of pregnancy does accomplish, using criminal law to declare certain behavior as nonmaternal defines ideal motherhood by negative implication. The ideal, in this mode, does not purport to be constructive; rather, it is overtly punitive.

In terms of the war on drugs, the prosecution of women as mothers is telling. A significant front of the "war" has been an attack on drug dealers and drug "lords."<sup>357</sup> The overt message is that women are responsible for society's drug problem. Women are an enemy in the war on drugs. Jennifer Johnson, Kimberly Hardy, and the fifty other pregnant women charged with drug offenses were prosecuted under laws intended for drug dealers. The covert message here is that failed motherhood is the cause of the problem; *i.e.*, the selfish and destructive conduct of mothers is creating a new generation of drug and alcohol abusers. Mothers are as bad as the drug dealers whose actions are devastating our cities and an entire generation of youth.

The corollary to the covert message is that women who are tempted to take drugs should not be mothers. These women are not capable of fulfilling the ideal; they breed disorder. Those women labelled "bad mothers" are the same women deemed bad mothers and subjected to sterilization abuse and forced medical intervention. Poor women of color are disproportionately subject to criminal prosecution.<sup>358</sup> They are being punished not for drug use, but for becoming childbearers.<sup>359</sup> Motherhood by women of color and poor women is

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<sup>355</sup> Stress caused by prosecution may harm fetal development. Imprisonment may actually increase harm to fetal development. A study of three California prisons revealed that more than one-third of the pregnancies of incarcerated women ended in late-term miscarriages. In one prison, only 21% of inmate pregnancies ended in live births. The conditions in all three prisons were found to be substantially below minimum standards set by the American College of Obstetricians and Gynecologists. See Susan LaCroix, *Birth of a Bad Idea: Jailing Mothers for Drug Abuse*, THE NATION, May 1, 1989, at 585, 585-88; Moss, *supra* note 324. In addition, as reported by Brenda Vaughn after serving the first thirty days of her sentence, drugs are available in jail. See *supra* note 224 and accompanying text.

<sup>356</sup> See LaCroix, *supra* note 355, at 585-88; Moss, *supra* note 324.

<sup>357</sup> Charles Lane, et al., *The Newest War*, NEWSWEEK, Jan. 6, 1992, at 18.

<sup>358</sup> See Gina Kolata, *Bias Seen Against Pregnant Addicts*, N.Y. TIMES, July 20, 1990, at A13 (of 60 women charged, 81% were women of color); see also Roberts, *supra* note 104, at 1421, n.6 (citing a memorandum prepared by the ACLU Reproductive Freedom Project: "Of the 52 defendants [women prosecuted for giving birth to babies testing positive for drugs], 35 are African-American, 14 are white, 2 are Latino, and 1 is Native American."); McNulty, Note, *supra* note 140, at 292-99.

<sup>359</sup> See Roberts, *supra* note 104, at 1445.

devalued by the ideology.<sup>360</sup> Motherhood by women of color and poor women is discouraged at law.<sup>361</sup>

The rationale behind the prosecutions, bills, and statutes seems to be that offered by Tony Tague. Tague supported his prosecution by stressing the deterrent effect of criminal law. He said that strong drug law enforcement is "the first step in protecting the newborn from the mother's selfish and destructive conduct."<sup>362</sup> This is the motherhood ideology. His version of the ideology assumes, of course, that persons addicted to drugs or alcohol, whether men or women, act voluntarily. As Judge Reilly of the Court of Appeals wrote, "[t]hat argument ignores the underlying problem of addiction and the compulsive behavior it generates."<sup>363</sup> Yet women can be prosecuted, in the name of the fetus, because they are pregnant.

Second, although Tague speaks of "the newborn," he speaks to the pregnant woman. She must, he says, act for the fetus, as if she alone can protect the child-to-be from social evils. This is not a new concept;<sup>364</sup> it is part of the ideology. It is, however, a new concept at law. Judge Reilly, at least, recognized that when he stated that "[t]his Court . . . is bound by the existing framework of our laws to refrain from transforming into a criminal act what is now essentially a moral obligation by the pregnant woman to her developing fetus."<sup>365</sup> Judge Reilly, however, appears to speak for the minority. The ideal is being transformed into law and, as such, mandates obligation and self-denial.

Third, whether or not Tague said it, when the state recognizes fetal personhood by prosecuting under old statutes or by enacting new ones, it acts to protect itself as well as innocent fetuses. The Wilson Bill paired the policy interests of preventing costs in terms of human suffering with that of dollar cost. The statutory text includes the following set of findings:

(4) the initial cost of providing care to infants suffering maternal substance abuse is over \$13,000,000,000 annually;

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<sup>360</sup> *Id.* at 1436.

<sup>361</sup> See McNulty, Note, *supra* note 140.

<sup>362</sup> *People v. Hardy*, 469 N.W.2d 50, 55 (Mich. Ct. App. 1991).

<sup>363</sup> *Id.*

<sup>364</sup> HALLER & HALLER, *supra* note 13, at 134 (quoting EMMA F. DRAKE, WHAT A YOUNG WIFE OUGHT TO KNOW 119 (1902)). Placing sole responsibility on pregnant women for avoiding social evils has a now-humorous precedent. In the nineteenth century, the pregnant woman was warned to avoid the taint of alcohol and tobacco on her husband's breath. The belief was that these fumes would influence the unborn child's future habits. "Many a little one is wailing through its infancy, and if it have strength yet will it all its life suffer from its antenatal and postnatal poisoning; and the chances are that as soon as it is old enough it will take up the habit which is already acquired, to pass down along the line a more enfeebled heritage." *Id.*

<sup>365</sup> *Hardy*, 469 N.W.2d at 55 (Reilly, J., concurring).

(5) the human cost in suffering and loss to society in terms of wasted potential of both the abusing mother and especially the abused and innocent child is both incalculable and avoidable;

(6) it is essential as a matter of both compassion and avoidance of unaffordable public expenditure that a maximum effort be made to prevent the recurrence of substance use during pregnancy.<sup>366</sup>

This is the same syllogism we have heard before.<sup>367</sup> Women are mothers. As mothers, women serve an important role in society. Because society has a strong interest in women as mothers, society can require women as mothers to take responsibility for its drug problem, and can do so by restricting access to the institution of motherhood.

#### d. *Child Neglect and Abuse Laws: Removing Children from Bad Mothers*

The use of civil neglect and abuse laws is premised on the same syllogism. The underlying story is the same. If a woman uses drugs or alcohol during pregnancy, the state steps in to protect the fetus or infant, and despite her addiction, the woman is blamed for voluntarily harming her child. The construct of conflict also replicates that of the criminal prosecution cases. The express issue is fetal personhood. The corollary, implied by the motherhood ideology, is maternal de-personhood. The real difference between the criminal prosecutions and the civil neglect cases is that the courts are more willing to recognize fetal personhood for purposes of civil neglect cases. Consequently, the state has a higher success rate in the courtroom, and women have a greater chance of losing their children and their liberty.

In terms of legal analysis, these cases are argued on one of two theories. Under the first theory, conduct during pregnancy is considered probative of future mistreatment. In these cases, the court purports to focus on the child's future well-being.<sup>368</sup> Under the second theory, the fetus is tacitly or expressly

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<sup>366</sup> S. 1444, 101st Cong., 1st Sess. § 2(a)(4)–(6) (1989). The Act further provides that “it is essential to reduce the incidence of substance abuse by pregnant women and the birth of infants addicted . . . or impaired . . . both for the sake of the mother and . . . infants . . . and to reduce the unaffordable costs in tax dollars.” *Id.* § 2(a)(11).

<sup>367</sup> See *supra* notes 24–25 and accompanying text.

<sup>368</sup> In at least two cases, the courts have said that prenatal conduct alone is insufficient to make a finding of neglect. But these courts go on to use the fact that the women are not enrolled in rehabilitation programs as the additional factor necessary to sustain a neglect finding. *In re “Male” R.*, 422 N.Y.S.2d 819 (Fam. Ct. 1979). “[I]t is far from clear that such impairment [withdrawal symptoms upon birth], caused as it was by *pre-natal* maternal conduct, would be sufficient, standing alone, to support a finding of neglect.” *Id.* at 824. The court cited the additional fact that Billie R. had failed to enroll in an alcohol or drug program. Despite the fact that the court could not establish actual neglect (because Billie R. never had custody), it concluded that “as a result of her ‘drug abuse,’ respondent is unable

accorded personhood status. In these cases, the focus is on the woman's conduct during pregnancy.<sup>369</sup> A California court using the second theory stated, "Troy was born with a detrimental condition caused by Mother's unreasonable acts of ingesting dangerous drugs while pregnant with him. This fact created a legal presumption that he is a person" who may be judged a dependent child of the court.<sup>370</sup> A New York court was less willing to presume harm. "[A] mother's pre-natal conduct alone cannot be the basis of neglect finding. Nor is it enough to claim abuse without showing a specific detriment to the new-born. The mother's pre-natal conduct must be connected to a post

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to properly care for her child." *Id.* at 820. *In re Stefanel Tyesha C.*, 556 N.Y.S.2d 280 (App. Div. 1990), the Family Court dismissed the neglect petitions "because prenatal conduct cannot form the basis of a finding of neglect." *Id.* at 282. The appellate division reversed and held that "the petitions sufficiently alleged causes of action for neglect based on the mothers' admitted use of drugs during their pregnancies, the children's positive toxicology for cocaine at birth and the failure of mothers to be enrolled in a drug rehabilitation program at the time the petitions were filed." *Id.*

<sup>369</sup> *In re Stephen W.*, 271 Cal. Rptr. 319, 323 (Ct. App. 1990) ("[T]he question is whether the facts alleged (urine screen was positive for opiates and infant displayed symptoms of opiate drug withdrawal) are legally sufficient to state a cause of action to declare a child a dependent of the juvenile court. We answer this question in the affirmative."); *In re Valerie D.*, 595 A.2d 922, 925 (Conn. App. Ct. 1991) (In this case, the state had a compelling interest in protecting Valerie, a living child born with a dangerous drug in her system, because her mother used that drug eight to ten hours before her birth. The fact that Valerie was at risk because of her mother's actions before her birth did not negate or dilute this compelling state interest.); *In re Baby X*, 293 N.W.2d 736, 739 (Mich. Ct. App. 1980) ("We hold that a newborn suffering narcotics withdrawal symptoms as a consequence of prenatal maternal drug addiction may properly be considered a neglected child."); *In re Fathima Ashanti K.J.*, 558 N.Y.S.2d 447, 448 (Fam. Ct. 1990) ("The court finds that the condition of the subject child at birth is the precipitating event warranting judicial intervention."); *In re Danielle Smith*, 492 N.Y.S.2d 331, 334 (Fam. Ct. 1985) ("Although the proof in the instant proceeding is insufficient to establish that the Respondent's abuse of alcohol, during pregnancy, actually caused fetal alcohol syndrome at the time of birth, the Court, nevertheless, holds that such proof was sufficient to establish an 'imminent danger' of impairment . . . to the unborn child."); *Dep't of Social Servs. v. Felicia B.*, 543 N.Y.S.2d 637, 638 (Fam. Ct. 1980) ("It is a basic rule of common law that one's actions instant may have consequences at a later time . . . Just as a cause of action against the doctor only arises if the child is born with a defect [citations omitted], the petition against the mother is only sustainable if the Petitioner proves that the child tested with a positive toxicology after its birth."); *In re Ruiz*, 500 N.E.2d 935, 935-36 (Ohio Comm. Pl. 1986) (Nora Ruiz admitted using heroin during the last two weeks of pregnancy and Baby Luciano's urine screen revealed cocaine and opiates. The court held that "a finding that a child is abused may be predicated solely upon the prenatal conduct of the mother.").

<sup>370</sup> *In re Troy D.*, 263 Cal. Rptr. 869, 872 (Ct. App. 1989).



birth risk of harm.”<sup>371</sup> The effect of both decisions, however, is to create a “reasonable pregnant woman” standard of behavior. That is, these statutes are being used to create a duty to the fetus, even if the fetus is not expressly being accorded personhood status.

In *In re Troy D.*,<sup>372</sup> the court all but recognized fetal personhood. The woman, Kelly D., argued on appeal that the court could not sustain the dependency petition because it was based on conduct with respect to a fetus.<sup>373</sup> The court agreed,<sup>374</sup> but followed the trial court’s reasoning that “the mother conducted herself in a manner that was dangerous to the child prior to the child’s birth but with full knowledge the child would be born,”<sup>375</sup> and found that “the petition was concerned with the protection of a living child, not with a fetus.”<sup>376</sup> In other words, although a fetus does not have the same legal status as a child under the child dependency statute, a pregnant woman must behave reasonably before the child’s birth in order to protect that unborn child. This imposes, whether the court admits it or not, a duty to the fetus.<sup>377</sup>

Some of the reported child neglect cases expressly recognize the fetus as a child.<sup>378</sup> Under this approach, it is easier to find that conduct during pregnancy may itself constitute neglect. A few courts have taken the next step and

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<sup>371</sup> *In re Milland*, 548 N.Y.S.2d 995, 998 (Fam. Ct. 1989) (citations omitted). Some written state policies provide that medical evidence of prenatal drug use is but one factor, among many, to be considered in assessing whether a child is abused or neglected. See, e.g., Judith Larsen, Robert Horowitz & Ira Chasnoff, *Medical Evidence in Cases of Intrauterine Drug and Alcohol Exposure*, 18 PEPP. L. REV. 279 (1981).

<sup>372</sup> 263 Cal. Rptr. 869 (Ct. App. 1989).

<sup>373</sup> *Id.* at 872.

<sup>374</sup> *Id.*

<sup>375</sup> *Id.* at 874. A good critique of this reasoning can be found in the opinion of a New York court addressing a similar petition. “To carry the law Guardian’s argument to its logical extension, the State would be able to supersede a mother’s custody right to her child if she smoked cigarettes during her pregnancy, or ate junk food, or did too much physical labor or did not exercise enough. The list of potential intrusions is long and constitute [sic] entirely unacceptable violations of the bodily integrity of women.” *In re Torres*, No. N-3968/88 (N.Y. Fam. Ct. 1988).

<sup>376</sup> *In re Troy D.*, 263 Cal. Rptr. at 873.

<sup>377</sup> It is doubtful the court would recognize a wrongful death claim against a woman whose pregnancy terminated as the result of drug use. In this sense, the court is not recognizing fetal personhood.

<sup>378</sup> *In re Danielle Smith*, 492 N.Y.S.2d 331, 335 (Fam. Ct. 1985) (Danielle Smith was born with fetal alcohol syndrome. The court held that “an unborn child is a ‘person’” and concluded that Danielle Smith was a “neglected child.”); *In re Ruiz*, 500 N.E.2d 935, 939 (Ohio Comm. Pl. 1986) (“[A] viable fetus is a child under the existing child abuse statute, and harm to it may be considered abuse under [the statute].”).

recognized a "right to begin life with a sound mind and body."<sup>379</sup> Since the other side of fetal right is maternal duty, a right to begin life with a sound mind and body places a huge onus on the pregnant woman in light of the acquired knowledge about fetal development.<sup>380</sup> Courts are using this knowledge to support recognition of fetal rights,<sup>381</sup> but the decisions rely upon assumptions about motherhood.

The courts rely heavily on toxicology reports and the testimony of medical experts in finding that conduct during pregnancy amounts to child neglect.<sup>382</sup> However, the courts are not necessarily following medical advice.<sup>383</sup> In *In re Stephen W.*,<sup>384</sup> the California appellate court agreed "with the reasoned analysis in *Troy D.*,"<sup>385</sup> and held that the "facts concisely describ[ing] Stephen's medical condition at birth, and particularly that he suffered withdrawal as a result of what appeared to be the mother's use of opiates

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<sup>379</sup> *In re Baby X*, 293 N.W.2d 736, 739 (Mich. Ct. App. 1980) ("Since a child has a legal right to begin life with a sound mind and body [citations omitted], we believe it is within this best interest to examine all prenatal conduct bearing on that right."); *In re Fathima Ashanti K.J.*, 558 N.Y.S.2d 447, 449 (Fam. Ct. 1990) (quoting John E.B. Myers, *Abuse and Neglect of the Unborn: Can the State Intervene?*, 23 DUQ. L. REV. 1, 60 (1984) ("[T]he unborn child possesses a right to a gestation undisturbed by wrongful injury and the right to be born with a sound mind and body free from parentally inflicted abuse or neglect.")); *Dep't of Social Servs. v. Felicia B.*, 543 N.Y.S.2d 637, 638 (Fam. Ct. 1989) (recognizing "the legal right of every human being to begin life unimpaired by physical, mental or emotional defects resulting from the neglectful acts of the parent [citation omitted]"); *In re Ruiz*, 500 N.E.2d at 939 ("a child does have a right to begin life with a sound mind and body.").

<sup>380</sup> See generally Harold Kalter, Ph.D. & Josef Warkany, M.D., *Congenital Malformations*, 308 NEW ENG. J. MED. 424 (1983); Suzanne M. Lynn, *Technology and Reproductive Rights: How Advances in Technology Can be Used to Limit Women's Reproductive Rights*, 7 WOMEN'S RTS. L. REP. 223 (1982).

<sup>381</sup> See *In re Fathima Ashanti K.J.*, 558 N.Y.S.2d at 448 (referring to numerous medical studies documenting the harmful effects of cocaine use during pregnancy).

<sup>382</sup> Of the nine civil child neglect cases cited, see *supra* notes 368-81 and accompanying text, six cited positive toxicology screens as a basis for finding neglect: *In re Fathima Ashanti K.J.*, 558 N.Y.S.2d 447 (Fam. Ct. 1990); *In re Baby X*, 293 N.W.2d 736 (Mich. Ct. App. 1980); *In re Troy D.*, 263 Cal. Rptr. 869 (Ct. App. 1989); *In re Stephen W.*, 271 Cal. Rptr. 319 (Ct. App. 1990); *In re Stefanel Tyesha C.*, 556 N.Y.S.2d 280 (App. Div. 1990); *Dep't of Social Servs. v. Felicia B.*, 543 N.Y.S.2d 637 (Fam. Ct. 1980); *In re Ruiz*, 500 N.E.2d 935. Each of these cases relied on testimony regarding symptoms indicating drug or alcohol exposure during gestation.

<sup>383</sup> See, e.g., *State v. Johnson*, 578 So. 2d 419, 420 (Fla. Dist. Ct. App. 1991). Although medical experts testified that it is impossible to tell whether cocaine metabolites pass to the child before or after birth, the court found that Jennifer Johnson had delivered a controlled substance through the child's umbilical cord after childbirth.

<sup>384</sup> 271 Cal. Rptr. 319 (Ct. App. 1990).

<sup>385</sup> *Id.* at 324.

during pregnancy”<sup>386</sup> were sufficient to take Stephen W. from his mother. But in doing so, the court ignored the California Medical Association which appeared as amicus curiae on behalf of Rayla W., the mother.<sup>387</sup> The opinion reverberates with the punitive nature and the high moral tone of these proceedings. This is particularly clear in the court’s finding that “the mother conducted herself in a manner that was dangerous to the child prior to the child’s birth but with full knowledge the child would be born.”<sup>388</sup> As noted earlier, this assumes, in defiance of medical knowledge, that all substance abusers act voluntarily. In addition, as Rayla W. argued, “[s]uch petition places moral blame on the status of drug users without any factual showing of the inability to parent.”<sup>389</sup> These cases are not only about protecting fetuses. They are also about describing women as sinners.<sup>390</sup>

When the courts remove a child from parental custody based on conduct during pregnancy, they “create rights in the fetus enforceable against the mother.”<sup>391</sup> The outcome is that fetal rights can be cited to impose significant control on the woman during pregnancy. Fetal rights advocates have proposed the “use of court orders to the mother to conform her conduct, at least where alcohol or drug abuse is involved.”<sup>392</sup> This would include “requiring the mother to see a doctor at fixed intervals for periodic testing.”<sup>393</sup> If the woman fails to submit, she could be found in contempt of court.<sup>394</sup> Proposals for fetal abuse statutes would authorize courts “to compel parents and prospective parents to enter alcohol and drug abuse rehabilitation programs,<sup>395</sup> and in the extreme, to take ‘custody’ of the fetus to prevent mental and physical harm.”<sup>396</sup>

In fact, several states have already enacted statutes<sup>397</sup> or introduced bills<sup>398</sup> that specifically extend the protection of child neglect laws to fetuses.<sup>399</sup> The

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<sup>386</sup> *Id.* at 323.

<sup>387</sup> *Id.* at 322 n.9.

<sup>388</sup> *Id.* at 324 (quoting *In re Troy D.*, 263 Cal. Rptr. 869, 874 (Dist. Ct. App. 1990)).

<sup>389</sup> *Id.* at 325.

<sup>390</sup> WERTZ & WERTZ, *supra* note 142, at 168 (describing another example of blaming women for social problems: “If a welfare patient [seeking prenatal care] could not afford the diet prescribed, many clinics still treated her noncompliance as a moral problem of self-control rather than as a problem of economics.”).

<sup>391</sup> *In re Stephen W.*, 271 Cal. Rptr. 319, 324 (Ct. App. 1990).

<sup>392</sup> Stearns, *supra* note 232, at 627–28.

<sup>393</sup> *Id.*

<sup>394</sup> *Id.*; Rickhoff & Cukjan, *supra* note 291, at 293–94.

<sup>395</sup> See *supra* notes 344–47 and accompanying text.

<sup>396</sup> Shaw, *supra* note 252, at 100.

<sup>397</sup> See, e.g., FLA. STAT. ANN. 415.503(9)(a)(2) (West Supp. 1992); ILL. REV. STAT. ch. 23, ¶ 2053 (1991); IND. CODE ANN. § 31-6-4-3.1 (West Supp. 1991); MINN. STAT. ANN. 626.556(2)(c) (West Supp. 1992).

<sup>398</sup> H.B. 416, Delaware, 135th Gen. Assembly (1989); S.B. 657, Maryland, 401st Legis. Sess. (1991); H.B. 1000, Maryland, 401st Legis. Sess. (1991).

Minnesota legislature has not only required doctors to report if they have reason to believe a woman is pregnant and has used a controlled substance for a nonmedical purpose, but it has also authorized local welfare agencies to seek an emergency admission "if the pregnant woman refuses recommended voluntary services or fails recommended treatment."<sup>400</sup> At least one court has approached the idea of involuntary medical treatment under child neglect laws,<sup>401</sup> while several have taken custody of a fetus,<sup>402</sup> and therefore of the pregnant woman. The regulation of women as wombs is more than theory.

The construct of maternal-fetal conflict is well-developed under child abuse and neglect laws. The conflict occurs on several levels. The right of a fetus to begin life with sound mind and body requires not only subordinating the pregnant woman, but also profiling a particular group of women—substance-addicted women—as "bad mothers."<sup>403</sup> Woman and fetus are defined as legal and moral adversaries.<sup>404</sup> Finally, fetal rights have been assigned social and political power in a way that subtracts from that of women as a class.

### e. *Conditioning Benefits on Good Conduct During Pregnancy*

Although laws do not expressly require pregnant women to comply with social workers' prenatal care recommendations in order to receive government benefits, conditional benefits have been proposed and seem possible in light of current regulations.<sup>405</sup> In other words, the government could predicate receipt of certain benefits upon compliance with standard prenatal care instructions,

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<sup>399</sup> For a critique of these statutes, see Robin-Vergeer, *supra* note 283.

<sup>400</sup> MINN. STAT. ANN. § 626.5561 (West Supp. 1992).

<sup>401</sup> *In re Danielle Smith*, 492 N.Y.S.2d 331, 332 (Fam. Ct. 1985) (Social workers urged Laureen Smith to seek treatment for alcohol abuse during her pregnancy, but she failed to do so. Upon the child's birth, the child was placed in foster care and the court ordered Ms. Smith "to complete a residential alcohol treatment program at a specified facility and to refrain from the abuse of alcoholic beverages."); *see also, In re Stephen W.*, 271 Cal. Rptr. 319, 322 (Ct. App. 1990) (The court ordered parents to submit to drug testing to "prove they remain drug free until the hearing."); *In re Stefanel Tyesha C.*, 556 N.Y.S.2d 280, 282 (App. Div. 1990) (The court did not order the pregnant women to seek rehabilitation for cocaine addiction, but it did base its finding of neglect in part on their failure to be enrolled in a drug rehabilitation program.); *In re "Male" R.*, 422 N.Y.S.2d 819, 821 (Fam. Ct. 1979) (The court did not directly order Billie R. to submit to treatment for her addiction to the barbituate, Tuinal, but it based its neglect finding in part on her unsuccessful participation in a drug program.).

<sup>402</sup> *See Kolder, supra* note 159, at 1193.

<sup>403</sup> *See supra* notes 325–27 and accompanying text.

<sup>404</sup> *See Stearns, supra* note 232.

<sup>405</sup> *See, e.g., Hillary Clinton's Plan for Prenatal Care*, S.F. EXAMINER, Aug. 26, 1992, at A6 (suggesting that women who do not seek prenatal care be denied welfare benefits as "the ultimate step" in getting expectant mothers to see health care professionals).

drug or alcohol rehabilitation, regular testing, and consent to medical treatment.

Government benefits have been conditioned on conceding reproductive choices to the state in the past. In the forced sterilization cases mentioned above, women had to "agree" to be sterilized in order to receive government support.<sup>406</sup> In several of the neglect cases, favorable custody determinations were premised in part on whether the woman had followed recommendations made by a social worker during the woman's pregnancy. State legislatures are considering and enacting a variety of programs to address the needs of substance-addicted women and infants.<sup>407</sup> It might seem a small step to condition access to these programs on compliance with government orders. Entitlement to WIC or AFDC benefits<sup>408</sup> could also be made conditional.<sup>409</sup> The prevailing assumptions at law about the primacy of fetal rights appear to support coerced compliance.

This potential extension of the regulatory scheme assumes that poor women have access to prenatal care. It is the easiest and most cost-effective way of reducing risks such as those associated with low-birth weight.<sup>410</sup> But, in fact, women who live in poverty have difficulty obtaining prenatal care.<sup>411</sup> This failure to acknowledge the reality of poor women's lives can be compared to similar failures with regard to women addicted to drugs and alcohol. It indicates that control of women, not preventing harm, is the real issue.

#### f. *Fetal Protection Policies*

One of the most insidious forms of reproductive regulation is the fetal protection policy. The fetal protection policy is the attitude, put into writing

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<sup>406</sup> See *supra* notes 109–16 and accompanying text.

<sup>407</sup> See *supra* notes 351–52 and accompanying text.

<sup>408</sup> McNulty, Note, *supra* note 140, at 296.

<sup>409</sup> See, e.g., CONN. GEN. STAT. § 17a-644 (1991); ORE. REV. STAT. § 430.925 (1990); S.B. 1173, Cal. 1989–90 reg. sess. (1989); S.B. 190, 86th Gen. Assem., Mo. (1991); S.B. 1197, Pa., 175th Gen. Assembly, 1991–92 reg. sess. (1991).

<sup>410</sup> See AMERICAN HOSPITAL ASSOCIATION, STATEMENT FOR THE RECORD TO THE NATIONAL COMMISSION TO PREVENT INFANT MORTALITY (July 1988); see also L. Rachel Eisenstein, *Prenatal Health Care: Today's Solution to the Future's Loss*, 18 FLA. ST. U.L. REV. 467 (1991); J. Athole Lennie, Joseph R. Klun & Tony Nauser, *Low-Birth-Weight Reduced by the Obstetrical Access Project*, 8 HEALTH CARE FIN. REV. 83 (1987).

<sup>411</sup> CHILDREN'S DEFENSE FUND, *The Nation's Investment in Children: An Analysis of the Presidents FY 1990 Budget Proposals* (1989); PREVENTING INFANT MORTALITY: INTERGOVERNMENTAL DIMENSIONS OF A NATIONAL PROBLEM: HEARINGS ON S. 1209 BEFORE THE SUBCOMMITTEE ON INTERGOVERNMENTAL RELATIONS, 99th Cong., 1st Sess. (1985).

and backed by the courts, that women can be controlled, excluded, and marginalized in order to protect fetal and other interests.

Until recently, employer rules which excluded women of childbearing age from jobs that exposed them to toxic substances were legal.<sup>412</sup> But the Supreme Court in *United Auto Workers v. Johnson Controls*<sup>413</sup> held that the fetal protection practice of the employer to exclude women with childbearing capacity from lead-exposed jobs violated the Pregnancy Discrimination Act of Title VII. "Johnson Controls' professed moral and ethical concerns about the welfare of the next generation do not suffice to establish a BFOQ [bona fide occupational qualification] of female sterility. Decisions about the welfare of future children must be left to the parents who conceive, bear, support, and raise them rather than to the employers who hire these parents."<sup>414</sup>

Although the Supreme Court's language is broad and general, parental choice here is tied to the Pregnancy Discrimination Act.<sup>415</sup> So, while some fetal protection policies are illegal, the actual prohibition extends only to those employers covered by Title VII.<sup>416</sup> And of Title VII employers who will now refrain from excluding women outright, but will instead provide them with "counselling and education" about health risks,<sup>417</sup> there is "concern that the counselling could become coercive."<sup>418</sup> Thus, fetal protection policies may survive in more than spirit.<sup>419</sup>

The protectionist attitude behind fetal protection policies is similar to that of Justice Brandeis in *Muller v. Oregon*.<sup>420</sup> It describes women as biologically determined to serve only as childbearers, implying that they are not necessary in the public sphere, at least not in the workplace. It assumes that women cannot and should not make decisions for themselves.<sup>421</sup> In fact, such thinking

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<sup>412</sup> *United Auto Workers v. Johnson Controls, Inc.*, 886 F.2d 871 (7th Cir. 1989), *rev'd*, 111 S. Ct. 1196 (1991); *Hayes v. Shelby Memorial Hospital*, 726 F.2d 1543 (11th Cir. 1984); *Wright v. Olin Corp.*, 697 F.2d 1172 (4th Cir. 1982).

<sup>413</sup> 111 S. Ct. 1196 (1991).

<sup>414</sup> *Id.* at 1207.

<sup>415</sup> 42 U.S.C. § 2000e(k) (1988).

<sup>416</sup> 42 U.S.C. § 2000e(b) (1988) defines "employer" as "a person engaged in an industry affecting commerce who has fifteen or more employees for each working day in each of twenty or more calendar weeks . . . but such term does not include (1) the United States, a corporation wholly owned by the Government of the United States . . . ."

<sup>417</sup> David O. Stewart, *Unleaded*, 77 A.B.A. J., at 38, 40 (1991) (quoting Stanley Jasan who argued before the Court on behalf of Johnson Controls).

<sup>418</sup> *Id.* at 40 (quoting Marcia Berzon, attorney for plaintiffs).

<sup>419</sup> In March 1991, two Seattle waiters were fired after refusing to serve a pregnant woman a strawberry daiquiri. The waiters received national attention and became local heroes for their efforts. Barbara Kantrowitz, et al., *The Pregnancy Police*, NEWSWEEK, April 29, 1991, at 52.

<sup>420</sup> See *supra* notes 34-35 and accompanying text.

<sup>421</sup> Becker, *supra* note 30, at 1229.

assumes that others, employers or the state, should decide for women that fetal interests are more important than the interests of women, and that limited autonomy for women "is a small price for mothers, potential mothers, and society to pay."<sup>422</sup> Perhaps the most damaging aspect of this attitude is that such an attitude ignores the effects it has on women. It reinforces the dilemma of disempowerment—that women bear the responsibility for societal problems and the next generation, but they do not deserve the authority to act responsibly.<sup>423</sup>

*g. Fetal Rights Acts*

The most far reaching regulation of pregnant women is the Fetal Rights Act. The current form of the Fetal Rights Act is a state policy statement that life begins at conception. The effect of this policy, if enacted, would be recognition of fetal personhood for all purposes, not just for the purposes of applying child neglect statutes. It would construct the maternal-fetal conflict in all contexts, and would provide justification for subordinating the interests of pregnant women in every situation.

Presumably, a statute asserting fetal rights for all purposes would violate a woman's right of privacy.<sup>424</sup> A woman could not, for example, obtain an abortion without violating the statute;<sup>425</sup> she might be committing murder. The Supreme Court narrowed a woman's right of privacy in *Planned Parenthood v. Casey*<sup>426</sup> by demoting the abortion decision from a fundamental right to a liberty interest. But the Court did affirm a constitutionally protected right to decide before viability. The United States Supreme Court, in *Webster v. Reproductive Health Services*,<sup>427</sup> addressed a statute containing the assertion that life begins at conception. The Court declined to address the constitutionality of the statement because it served only as a preamble and did not amount to a restriction on abortion.<sup>428</sup> However, by allowing the preamble

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<sup>422</sup> Ronald Bayer, 60 MILBANK MEMORIAL FUND Q. HEALTH & SOC'Y 422, 644 (1982) (quoting a representative from the Synthetic Organic Chemical Manufacturers Association).

<sup>423</sup> See, e.g., Kim Dayton, *Patriarchy, Paternalism and the Masks of "Fetal Protection,"* 2 KAN. J.L. & PUB. POL'Y 25 (1992).

<sup>424</sup> See *Webster v. Reprod. Health Servs.*, 492 U.S. 490, 504-07 (1989).

<sup>425</sup> See Johnsen, *supra* note 328, at 197-204; Harriet F. Pilpel, *Hyde and Go Seek: A Response to Representative Hyde*, 27 N.Y.L. SCH. L. REV. 1101 (1982); David Westfall, *Beyond Abortion: The Potential Reach of a Human Life Amendment*, 8 AM. J.L. & MED. 97 (1982).

<sup>426</sup> See *supra* note 94.

<sup>427</sup> 492 U.S. 490 (1989).

<sup>428</sup> *Id.* at 506.

to stand, the Court left the door open for states to express the idea of fetal personhood and of regulating pregnant women.<sup>429</sup>

Attempts have been made to pass fetal rights legislation at the federal level. A number of "Human Life Bills" have been introduced during the last decade. Among them were proposed legislation "[t]o provide that human life shall be deemed to exist from conception,"<sup>430</sup> a bill "[t]o amend the Civil Rights Act of 1964 to protect the rights of the unborn,"<sup>431</sup> and a joint resolution "[p]roposing an amendment to the Constitution of the United States for the protection of unborn children and other persons."<sup>432</sup> These bills were apparently attempts to restrict a woman's right to decide whether to terminate a pregnancy. If a human life bill were enacted now, however, it could present an even wider range of restrictions on reproductive freedom. Such a bill could tap into the potential for completely regulating pregnant women that recent laws have indicated.

### 3. *The Evolving Ideology of Motherhood: Summary*

The regulatory scheme, expanded to restrict choices implicated by continued gestation as well as those surrounding conception, includes both direct and indirect state intervention. As discussed, these interventions subtract from the bodily integrity and decisional autonomy of the woman. To the extent that the state invokes the *parens patriae* power to prevent harm to the fetus, the state subordinates the interests of the woman to those of the fetus. To the extent that the state regulates pregnant women to promote public health, safety, and morals—an exercise of the police power—it subordinates the interests of the

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<sup>429</sup> ILL. REV. STAT. ch. 38, ¶ 81-21 (1991); LA. REV. STAT. ANN. § 40.1299.35.0 (West 1991); MO. REV. STAT. § 1.205 (1986); UTAH CODE ANN. § 76-7-301.1(1) (1991).

<sup>430</sup> S. 158, 97th Cong., 1st Sess. (1981) (introduced by Sen. Jesse Helms) (providing that unborn are "persons" for the purpose of the Fourteenth Amendment's right to life guarantee); S. 1741, 97th Cong., 1st Sess. (1981) (introduced by Rep. Hyde) (providing that life begins at conception and that all human beings are persons for the purpose of enforcing the Fourteenth Amendment right to life); H.R. 900, 97th Cong., 1st Sess. (1981) (deeming that human life begins at conception); J.R. 3225, 97th Cong., 1st Sess. (1981) (providing that unborn are "persons" until the Constitution is amended to protect the life of the unborn).

<sup>431</sup> S. 522, 99th Cong., 1st Sess. (1985) (introduced by Sen. Hatch) "Nothing contained in the Civil Rights Act of 1964 shall be construed to authorize the use of Federal financial assistance for abortions and no such assistance shall be used to perform abortion except where the life of the mother would be endangered if the fetus were carried to term." *Id.* § 606.

<sup>432</sup> H.J. Res. 62, 97th Cong., 1st Sess. (1981) (introduced by Rep. Rhodes) (including "unborn offspring at every stage of their biological development" in the definition of "person" for the purpose of the Fifth and Fourteenth Amendment guarantees to life. "Provided, however, that nothing in this article shall prohibit a law permitting only those medical procedures required to prevent the death of the mother.").



woman to those of the rest of society. In either case, when the state regulates women as childbearers, it legislates the ideology of motherhood. Furthermore, it eliminates the possibility of self-definition.

The ideology, in regulatory form, creates two other effects that run across the direct-indirect organizational line: devaluing women as persons and devaluing women as mothers. Both of these effects describe women in terms other than humanist. That is, both effects are reductionist.

These regulations devalue women as persons by characterizing women as wombs. These laws treat women not as persons but as fetal containers, wombs surrounded by resources in human shape. The part of the ideology articulated through these regulations is that of women as mothers raising their children to contribute to the social order.<sup>433</sup> They are means to an end.<sup>434</sup> Now, in order to give these children a head start, their mothers are made guarantors that they will begin life with sound minds and bodies. It is women, as individuals, who bear this responsibility. It is women, as a group, who are devalued by the experience of childbearing under law.

These regulations also devalue some women as mothers. Regulations that infringe on women by race and class express the part of the ideology that motherhood as an institution has the charge of transmitting social rules, as well as moral and cultural values. Some women, according to these laws, are unfit to accomplish this task. Because they depart from the norm, they are likely to breed disorder.

When reviewed with a critical eye, the motherhood ideology as a regulatory scheme discloses the current social concerns. Social concerns have been translated by ideology into fears of woman-bred disorder, points at which women have failed as buffers. Many of the laws express a faith that the road to social order lies in genetic determinism. Many of the laws also reveal the influence of pro-life doctrines. And many of the laws, especially indirect regulations, reflect the fear generated by the war on drugs. In terms of history, the cultural practice of using women as buffers against disorder is an old one, but its current expression—state regulation of pregnant women—is new.

#### IV. THE PRACTICE OF DEFAULTING TO SCIENCE AND THE INTERVENTIONIST MINDSET OF LAW

The regulation of pregnant women is an elaboration of the ideology of motherhood and an unprecedented use of state power. The extension of state power raises the question—why has the regulatory scheme expanded to restrict choices implicated by pregnancy? Many have noted that the sphere of activity

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<sup>433</sup> See *supra* notes 13–16 and accompanying text.

<sup>434</sup> See ROTHMAN, *supra* note 14, at 43–45.

protected from state intervention is shrinking.<sup>435</sup> But, state regulation premised on the socially-constructed ideology of motherhood is the key. It focuses the heavy power of the state on women. This regulation allows the state to present its restrictions on women as natural and the idea of self-definition for women as unnatural. This regulation gives the regulatory scheme its shape and character.

There are, however, other forces propelling the formation of a regulatory scheme at this time. In this section, I explain the regulation of pregnant women as the intersection of the motherhood ideology and of two other forces. One I call defaulting to science. It is the practice of letting developments in science and technology<sup>436</sup> define the issues in a way that creates an imperative to use these developments. The other force is an interventionist mindset of law. This is a willingness that stems from a failure to consider alternatives, to use state power in a way that restricts individual choice and self-definition.

### A. Defaulting to Science

Defaulting to science is another way of saying that we equate, without thinking about it, science with progress.<sup>437</sup> New developments in science and technology are being used in many cases simply for the sake of using them. We default to science when we assume that if the technology is there, we should use it, and then we act on this assumption without critical evaluation of the wisdom of acting.<sup>438</sup>

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<sup>435</sup> See, e.g., LAURENCE H. TRIBE, *AMERICAN CONSTITUTIONAL LAW* 8–9 (2d ed. 1988); Homer H. Clark, Jr., *The Role of Court and Legislature in the Growth of Family Law*, 22 U.C. DAVIS L. REV. 699 (1989); William M. Kunstler, *The Bill of Rights—Can it Survive?*, 18 N.Y.U. REV. L. & SOC. CHANGE 5 (1990–91); Charles A. Reich, *The Individual Sector*, 100 YALE L.J. 1409, 1412 (1991).

<sup>436</sup> I use “science” and “technology” together, in part, to express the idea that they are indivisibly paired by the same political and economic concerns for which they are developed and deployed. See STANLEY ARONOWITZ, *SCIENCE AS POWER: DISCOURSE AND IDEOLOGY IN MODERN SOCIETY* 6–34 (1988).

<sup>437</sup> *Id.* at 3–6 (citing examples where science and technology have been accepted as progress despite great harm).

<sup>438</sup> This generalization has a few welcome exceptions. For example, some federal regulations provide procedures aimed at provoking critical evaluation of proposed research projects. The FDA screens many products of science and technology. Moreover, there have been moments where scientists have themselves paused for thought—for example, at the Asimolar Conference scientists called for a moratorium on recombinant DNA work. This proved short-lived. I am describing a mindset, a set of assumptions about science and technology that have become a cultural practice.

### 1. *Development of the Practice of Defaulting to Science*

In obstetrics, the practice of defaulting to science took shape during the late nineteenth and early twentieth centuries, the time when medical professionals acquired their status and influence.<sup>439</sup> It was, as mentioned above,<sup>440</sup> a time when physician participation in childbirth became standard.<sup>441</sup> As technology for intervention became available, it raised the question of whether it should be used. But that question was not addressed at the outset. As the means of medical intervention became available, physicians simply used them as a matter of course. By assuming that the new science or technology should be used, physicians simultaneously created an imperative for its use.

History shows that the use of forceps and anesthesia in the delivery room became standard for reasons that had little to do with reducing maternal and infant mortality.<sup>442</sup> Hospital births became common,<sup>443</sup> and physicians used technology to intervene simply because the equipment was available.<sup>444</sup> When physicians participated in home births, they intervened because they felt pressured in the presence of others to do something, to “perform.”<sup>445</sup> And some physicians, if pressed for time and other patients were waiting, used forceps, anesthesia, or both to direct labor into patterns under their control.<sup>446</sup>

As the means of physician control became available, the experts constructed a need for it. They characterized childbirth as a process where harm might occur but for the use of forceps,<sup>447</sup> episiotomies,<sup>448</sup> ergot,<sup>449</sup> anesthesia,<sup>450</sup> and cesarean sections.<sup>451</sup> One of the first results of physician

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<sup>439</sup> EHRENREICH & ENGLISH, *supra* note 178, at 69; WERTZ & WERTZ, *supra* note 142, at 9; *see also*, LEAVITT, *supra* note 178, at 172–82 (describing the increasing number of hospital childbirths, due in large part to the enhanced reputation of the practice of medical science). “However, in obstetrics it was more the image of science’s potential, the lure of what science could offer, than any proven accomplishments that attracted women to the hospital.” *Id.* at 373.

<sup>440</sup> *See supra* note 178 and accompanying text.

<sup>441</sup> *See supra* notes 183–85 and accompanying text. *See also* WERTZ & WERTZ, *supra* note 142, at 46–47.

<sup>442</sup> LEAVITT, *supra* note 178, at 142–70 (discussing three reasons for continued obstetrical problems, and focusing on the role of physicians in causing or increasing women’s problems).

<sup>443</sup> LEAVITT, *supra* note 178, at 174, 179.

<sup>444</sup> *Id.* at 182.

<sup>445</sup> WERTZ & WERTZ, *supra* note 142, at 63–64.

<sup>446</sup> *Id.*; LEAVITT, *supra* note 178, at 120.

<sup>447</sup> LEAVITT, *supra* note 178, at 179.

<sup>448</sup> *Id.* at 142, 152.

<sup>449</sup> *Id.* at 147.

<sup>450</sup> *Id.* at 122, 127–41 (twilight sleep debate); WERTZ & WERTZ, *supra* note 142, at 150.

participation in reproduction was a changed understanding of childbirth, from a natural but risky event, to a pathology.<sup>452</sup> Similarly, as the means for intervention in fetal development become available, pregnancy is coming to be understood as a pathology. It is being characterized as a process where harm might occur but for the imposition of medical treatment and behavior restrictions on the pregnant woman. Science provides the reason for, as well as the means of, taking control.

When we default to science, we cede control to the experts and institutions who have the technology. Physicians exercise control by prescribing both the problem—potential risks during pregnancy—and the solution—taking control of the biological processes. Science, the need for information, and technology developed by science become one and the same. But by assuming necessity, we fail to consider fully the consequences of ceding control. When courts order forcible medical treatment, and when judges and legislatures create legal sanctions for certain behavior for the ostensible reason of preserving fetal health, they may consider that imposing control over the biological processes of pregnancy means taking control of the pregnant woman's body, but they fail to consider that imposing control over a woman because she is pregnant means defining women as fetal carriers and devaluing them as individuals. That consideration is not subject to "scientific" proof. It is, however, fast becoming a political truth.

## 2. *Science as Neutrality*

Science appeals as an authority because we take it to be uncompromising, neutral, and disinterested.<sup>453</sup> We take science to be ahistorical<sup>454</sup> and

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<sup>451</sup> WERTZ & WERTZ, *supra* note 142, at 161.

<sup>452</sup> In "Kuhnsian" terms, once childbirth-as-pathology became accepted as a paradigm, novel means of physician intervention in the childbirth process were readily accepted and, as stated, justified as necessary. They merely confirmed the paradigm. And at the most, new means of intervention such as the use of anesthetics required a reformulation of the paradigm. Physician control, then, may be described as a micro-version of what Kuhn calls "normal science." THOMAS S. KUHN, *THE STRUCTURE OF SCIENTIFIC REVOLUTIONS*, 23–30 (2d ed. 1970). *See also*, EHRENREICH & ENGLISH, *supra* note 178, at 111; WERTZ & WERTZ, *supra* note 142, at 136, 141, 165.

<sup>453</sup> *See* ARONOWITZ, *supra* note 436, at 6 ("It is still true, however, that most students of science, while acknowledging the influence of what is often labeled "cultural factors" in the process of knowledge acquisition, insist that economic, political, and ideological questions must be strictly demarcated from considerations bearing on the content of scientific knowledge."); EHRENREICH & ENGLISH, *supra* note 178, at 77 ("It is this image of uncompromising disinterestedness and objectivity which gives science its great moral force in the mind of the public."); SANDRA HARDING, *THE SCIENCE QUESTION IN FEMINISM* 225–29 (1986) (Harding identifies the three primary characteristics of the myth of modern science as atomism, value-neutrality, and experimental observation.).

apolitical.<sup>455</sup> We also treat science as authority because it is something performed by experts. That is, science is something we cannot question because we lack the requisite skills and training to do so.<sup>456</sup> We must rely on experts. We have been willing to rely on experts largely because we believe that experts perform science according to neutral principles, and that they are disinterested in the knowledge acquired through science.<sup>457</sup> Neutrality is considered necessary to rational individualism and a just society—it has moral force.<sup>458</sup> According to western logic, knowledge derived from neutral principles carries weight as truth.<sup>459</sup>

Defaulting to science depends on our willingness to make a large set of assumptions. When we defer to science as truth, we assume that neutrality is

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<sup>454</sup> See KUHN, *supra* note 452 (questioning the role of history in the image of science, and in doing so, describing a scientific community largely separated and autonomous from other intellectual and political pursuits of the historical period in which new theories emerged).

<sup>455</sup> But see HARDING, *supra* note 453 and ARONOWITZ, *supra* note 436.

<sup>456</sup> For example, despite the doctrine of informed consent, most patients do not ask questions. They do not know what to ask and they are intimidated by the process. They feel so alienated from their bodies because of the doctor's more technical (and therefore, they assume, more valid) information that they simply accept the doctor's recommendation as fate.

<sup>457</sup> EHRENREICH & ENGLISH, *supra* note 178, at 69 (summing up the impact of the image of science on the lay public: "The judgment of the 'results'—the graphs, columns of figures, comparative measurements—is final."); see also HARDING, *supra* note 453, at 228 (identifying "the most powerful symbol of the new science" as "method" and analogizing "rule by method" to nature's "rule of law"; as administrators of "rule by method," then, scientists are assumed to act impersonally and their authority cannot be questioned).

<sup>458</sup> See DON HERZOG, *HAPPY SLAVES: A CRITIQUE OF CONSENT THEORY* 148–56, 171–81 (1989).

<sup>459</sup> There are several understandings of "truth." Two are relevant here. One refers to a "verifiable reality," as Professor Faigman calls it. Science typically uses this standard to define empirical evidence. See David L. Faigman, *To Have and Have Not: Assessing the Value of Social Science to Law as Science and Policy*, 38 EMORY L.J. 1005, 1016–21 (1989). Yet another assumes in a more general way that truth is value-neutral knowledge, the product of applying value-neutral principles to human social life. Laurence H. Tribe & Michael C. Dorf, *Levels of Generality in the Definition of Rights*, 57 U. CHI. L. REV. 1057 (1990). I would question the validity of the second of these understandings. It assumes that there are some human events that all persons would interpret in the same way. That is, it assumes some level of universal experience. The effect, however, of applying "value-neutral" standards is inapposite to the assumption of a universal experience—it identifies persons and groups who have not had the experience described by the standard. *Id.* at 1062, 1086. "Verifiable reality" seems useful when presented as one of many types of truth. See K. POPPER, *THE LOGIC OF SCIENTIFIC DISCOVERY* 39 (1959) ("The system called 'empirical science' is intended to represent only *one* world: 'the real world' or the 'world of our experience.'") (citation omitted). But we default to science when we cite verifiable reality as the "best" or only truth. It is then that we fail to consider and value human experience.

possible, that scientific truth is derived from neutral principles, that only some persons known as experts are capable of ascertaining these truths, and that the experts act disinterestedly.<sup>460</sup> The most significant assumption we make is that we lack the ability to question science. It is a matter of cultural practice, not scientific method, that we not only assume that the experts have the learning and training to perform science, but also that they should determine whether and how the scientifically-produced knowledge should be used. It is at this point that we default to science.

The regulation of pregnant women has come about by defaults occurring within several institutions at once. I have described the default by experts, the "go-ahead" attitude of scientists employing new technologies and scientifically-developed information. I have also described the default that occurs as a broader cultural practice. This practice first creates a social norm. The norm is expressed when a woman consents to medical intervention in her pregnancy because the decision accords with the assumption that technology is necessary and good. At this point, the individual decision to defy the norm is still possible. A woman could choose to refuse surgery, or to consume alcohol as a protected right under the common law right to refuse treatment,<sup>461</sup> or under the constitutional principles of bodily integrity and decisional autonomy.<sup>462</sup> But when the default to science occurs at law, the concept of choice alters. Choice can be discarded when scientific information or technology is recognized as a state interest or imposed as a duty. Choice may disappear altogether, as under direct regulation. Or it may become a smaller idea, something more like directed behavior than self-constituting choice, under indirect regulation.

### 3. *Default Upon Default*

A slightly different effect of the practice of defaulting to science is that the initial failure to address seriously the question of whether the information or technology should be used perpetuates itself. That is, through science, information or technology is derived. The derived technology or information is implemented by default, not by decision. Simultaneously, its necessity becomes lore, and it is assumed that more of the same is desirable, if not necessary. Similar science will be more readily implemented. It rests on an assumption of necessity already proven.

The availability of prenatal testing illustrates this effect. Because it is available, amniocentesis is used. Amniocentesis provides valuable

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<sup>460</sup> See HARDING, *supra* note 453, at 30-57.

<sup>461</sup> See *Cruzan v. Director Missouri Dept. of Health*, 497 U.S. 261, 261-63 (1990).

<sup>462</sup> See *Union Pacific R. Co. v. Botsford*, 141 U.S. 250 (1891); *Schloendorff v. Society of New York Hosp.*, 105 N.E. 92 (1914).

information<sup>463</sup> but also presents risks.<sup>464</sup> Presumably some risk-benefit analysis was performed when these technologies were first introduced,<sup>465</sup> but it became standard so quickly as to belie thorough assessment of the risks and exploration of alternatives, including that of not using the technology at all.<sup>466</sup> Amniocentesis may seem so obviously beneficial, and so low risk, that using it as an example here appears inappropriate or paranoid. That illustrates the point: the medical community and the general public have accepted prenatal testing so completely that its necessity is common lore. The speed and completeness of its acceptance followed from the assumption that if it is "science," it must have utility. The acceptability of this test is no longer open to question.<sup>467</sup>

Now, the physician may describe the risks to each woman before administering the amniocentesis, but because it has become part of common

<sup>463</sup> See Gina Kolata, *First Trimester Prenatal Diagnosis: A New Method of Prenatal Diagnosis May Largely Replace Amniocentesis*, 221 SCIENCE 1031 (Sept. 9, 1983).

<sup>464</sup> Complications of amniocentesis include vaginal bleeding and amniotic fluid leakage. The NICHD National Registry for Amniocentesis Study Group, *Midtrimester Amniocentesis for Prenatal Diagnosis*, 236 JAMA 1471, 1471 (1976).

<sup>465</sup> But see *id.* at 1471 ("Since the first reports of the use of midtrimester amniocentesis for prenatal diagnosis of chromosomal and metabolic disorders . . . in 1967 and 1968, use of the procedure has grown to the point that approximately 3,000 women had amniocentesis performed . . . in 1974 . . . . Surveys of use of the technique have focused primarily on reasons amniocentesis was performed and accuracy of the diagnostic procedure rather than on its safety.").

<sup>466</sup> See T.A. Doran et al., *The Antenatal Diagnosis of Genetic Disease*, 118 AM. J. OB. & GYN. 314, 314-15 (1974) (summarizing the "rapid advances in antenatal diagnosis" made possible by amniocentesis. Steel and Breg first successfully cultured amniotic cells in 1966. In the next five years, scientists reported the first in utero diagnosis of genetic and biochemical disorders. During that same time period, amniocentesis became standard for all pregnant women over 40.).

<sup>467</sup> See, e.g., Kolata, *supra* note 463 ("A new technique ['chorionic villus biopsy'] for obtaining fetal cells for prenatal diagnosis, now being tested in the United States and Europe, may largely replace amniocentesis within the next few years, clinical researchers predict." Chorionic villi biopsy permits prenatal screening for genetic and biochemical defects, as does amniocentesis. The test can be made during the first trimester and results obtained within a few days. Amniocentesis is performed during the second trimester, followed by a two to three week wait for results.). See also Shaw, *supra* note 252, at 76-78 (describing chorionic villus testing as non-invasive, although it is performed by inserting a catheter into the woman through the cervix, and using suction to remove a sample of chorionic tissue surrounding the fetus. It is less invasive than amniocentesis, so that it could be performed with less risk to women. Shaw suggests on that basis that "an argument could be made for screening *all* pregnancies or at least offering the mother the option of CVB even if no increased risks to the fetus are discerned [than those identified by the current practice of using amniocentesis on pregnant women over the age of thirty-five]." *Id.* at 76-77. In that sense, it is clearly more invasive.).

lore that the procedure is necessary, most women will "consent" as a matter of course. When the risks of testing are discussed, direct physical risks to the fetus and woman are raised. However, perhaps the greatest unexplored risks of prenatal testing are the ethical dilemmas raised by the revealed information.<sup>468</sup> Prenatal testing may reveal gender. It may also yield the presence of a physical defect or disease. This information then raises the issue of whether anything should be done to prevent, repair, or mitigate the defect, and if so, what should be done. Although information that a disease or defect exists does not mean that a treatment is available,<sup>469</sup> many assume that *something* should be done. Hence, proposals for selective abortion and forced in utero therapy arise.<sup>470</sup> The desire to intervene in these cases probably originates from a sense of humanity, a desire to prevent harm to others—fetuses. That seems good. However, there is an impetus for intervention without full consideration of the consequences. The practice of defaulting to science permits this intervention without consideration.

The ethical discussion of whether to act on information gained has occurred largely within the context of genome projects.<sup>471</sup> The concerns seem removed from the more everyday context of prenatal care. It seems unlikely now that thorough assessment of the risks and alternatives to prenatal testing will ever be performed. In fact, there is a push to implement other, more revealing types of prenatal testing.<sup>472</sup> The authority of science lies in a claim to

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<sup>468</sup> See, e.g., Kolata, *supra* note 463 (reporting use of information gained from chorionic villus biopsy to abort female fetuses in China and Russia); NICHD National Registry for Amniocentesis Study Group, *supra* note 464, at 1475 (describing risk of diagnostic errors resulting in elective abortions); Wertz, *supra* note 142, at 248–52 (discussing the potential negative consequences of "information overload," increased sexual stereotyping, and sex-selective abortions).

<sup>469</sup> Examples include Tay Sachs, cystic fibrosis, and Huntington's.

<sup>470</sup> See generally Hubbard, *supra* note 138; Mathieu, *supra* note 241; Robertson, *supra* note 238; Shaw, *supra* note 252; Stearns, *supra* note 232. The ability to perform in utero therapy is creating its own need.

<sup>471</sup> For a description of the Human Genome Initiative, see generally U.S. OFFICE OF TECHNOLOGY ASSESSMENT, MAPPING OUR GENES, THE GENOME PROJECTS: HOW BIG, HOW FAST? (1988); Charles Marwick & Beverley Merz, *Gene Mappers Form Collaborations*, 260 JAMA 2477 (Nov. 4, 1988); Joseph Palca, *Genome Projects Are Growing Like Weeds*, 245 SCIENCE 131 (July 14, 1989). For ethical discussions, see generally JERRY E. BISHOP & MICHAEL WALDHOLZ, GENOME (1990); EVE K. NICHOLS, HUMAN GENE THERAPY (1988); DAVID SUZUKI & PETER KNUDSON, GENETHICS: THE CLASH BETWEEN THE NEW GENETICS AND HUMAN VALUES (rev. ed. 1990); W. French Anderson, *Human Gene Therapy: Scientific and Ethical Considerations*, 10 J. MED. & PHIL. 275–91 (1985); George Annas, *Mapping the Human Genome and the Meaning of the Monster Mythology*, 39 EMORY L.J. 629 (1990).

<sup>472</sup> See, e.g., Shaw, *supra* note 252, at 76–78 (Restriction fragment length polymorphisms are used to map the human genome. Its use for prenatal testing has already



truth. When we default to science, we accept without question similar claims as truth.

#### 4. *The Construct of Conflict*

The maternal-fetal conflict has been constructed in large part by defaulting to science. Scientific "truth" determines how we perceive and treat human beings—medically, socially, and politically. Modern science presents human life as "a system of 'organized complexity' whose driving force is the molecular structure of the gene."<sup>473</sup> The greatest single truth derived from our rapidly increasing knowledge of fetal development is that fetal life is complex and physically vulnerable to its environment. That "truth" provides a rationale for regulating pregnant women—it is environmental quality control. The scientific description of human life as biologically determined provides the rationale for elevating the importance of fetal life.

Science and technology also shape our understanding of pregnancy. As forceps and the episiotomy transformed the understanding of childbirth from natural event to pathology, technology such as the sonogram has changed the literal picture of pregnancy. The earlier model for the woman-fetus relationship was interdependence. Law followed this model. Unborn fetuses had very few legal interests at law.<sup>474</sup> Now, doctors regard the fetus as a separate patient,

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been suggested.). See Botstein, et al., *Construction of a Genetic Linkage Map in Man Using Restriction Fragment Length Polymorphisms*, 32 AM. J. HUMAN GENET. 314, 328 (1980). It may be possible in a few years to identify every genetic trait prenatally. The argument that such testing should be performed because it is possible carries much weight in a society characterized by the practice of defaulting to science.

<sup>473</sup> ARONOWITZ, *supra* note 436, at 15.

<sup>474</sup> Fetuses were first accorded legal status in property law. Fetuses were considered "lives in being" for purposes of taking property by intestacy, devise, or bequest but could only actually take title if born alive. *Bonbrest v. Kotz*, 65 F. Supp. 138, 140 (D.D.C. 1946). See also *Roe v. Wade*, 410 U.S. 113, 161 (1973). Until 1946, there was no tort liability for injury sustained before birth. *Bonbrest*, 65 F. Supp. at 139 (holding that a viable fetus could recover for injury allegedly caused by doctors' negligence if born alive. This was the first case to reject the rule precluding recovery for injury to a fetus.). A majority of jurisdictions have recognized wrongful death actions for negligence that terminates a viable pregnancy. A few jurisdictions have extended liability for non-viable fetuses. W.P. KEETON, ET AL., PROSSER & KEETON ON THE LAW OF TORTS § 55, at 368-69 (5th ed. 1984). Courts also used the live birth requirement in criminal cases. See *Commonwealth v. Cass*, 467 N.E.2d 1324, 1328 (Mass. 1984) ("Since at least the fourteenth century, the common law has been that the destruction of a fetus in utero is not a homicide . . . [T]he rule has been accepted as the established common law in every American jurisdiction that has considered the question.").

and the law recognizes the fetus as a being with independent interests.<sup>475</sup>

The important point is that once the two-patient model is accepted, conflict is assumed to be inevitable. This conflict is a cultural construct, not the result of "pure science." Relationships in our society are only dimly understood in terms of power and subordination. It is as if relationships characterized by domination and subordination are inevitable and unchangeable. They are more often described in terms of conflict and a balance of interests. It is true that our package of values includes the equality principle, which seems to acknowledge the need to eliminate subordination. But the equal protection doctrine is more often valued as a means of addressing only the obviously harmful results of subordination.<sup>476</sup> Hierarchy, not liberation, is the presumably immutable starting point in describing relationships. This cultural understanding prescribes the perception that in a woman-fetus relationship, the woman is in a position of power relative to the fetus, and the fetus must be protected in order to prevent harm caused by the woman's abuse of power. Since it is easier to perceive a power relationship and conflict between identifiably separate interests, the two-patient model enhances the construct of conflict.<sup>477</sup> But the model is being accepted with little consideration being given to the potential harm of describing pregnancy as the source of conflict.

Generally, the effect of using a two-patient model for pregnancy is that attention shifts to the fetus. This may have the good of promoting fetal health, but in some situations it detracts from the woman's interests. Cases discussed in Part II illustrate this point.<sup>478</sup> Where petitions for court-ordered medical treatment are sought, judges usually grant the petition. The decision to grant the petition appears almost reasonable if one considers the information received

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<sup>475</sup> Barbara Katz Rothman has suggested that the model of motherhood as "the physical embodiment of connectedness" challenges liberal philosophy, which focuses on individuality and separation. ROTHMAN, *supra* note 14, at 59. Perhaps, if anything, the predominance of liberal philosophy makes it impossible for us to imagine and appreciate that interdependence exists.

<sup>476</sup> See Richard Delgado, *When a Story is Just a Story: Does Voice Really Matter?*, 76 VA. L. REV. 95, 102-03 (1990) (describing civil rights in the purview of the dominant discourse as "the study of communities in conflict; its objective is the management of tension").

<sup>477</sup> I am not saying that the construct of conflict began recently, only that recent developments in the scientific and social understanding of pregnancy have expanded and sharpened the construct. The debate through the centuries about whether a fertilized ovum contained a soul suggests a maternal-fetal conflict. See John T. Noonan, Jr., *An Almost Absolute Value in History*, in *THE MORALITY OF ABORTION* 1-59 (John T. Noonan, Jr., ed. 1970) (presenting the Christian humanist perspective on the philosophical debates over the legality of abortion through western history).

<sup>478</sup> See *In re Madyun*, 114 Daily Wash. L. Rep. 2233 (D.C. 1986); *In re A.C.*, 533 A.2d 611 (D.C. 1987), *reh'g granted*, 539 A.2d 203 (D.C. 1988), *on reh'g*, 573 A.2d 1235 (D.C. 1990); *Jefferson v. Griffin Spalding County Hosp.*, 274 S.E.2d 457 (Ga. 1981).

and the setting in which the judge must make a decision. The doctor informs the judge that she has the ability to prevent harm to the fetus or to correct a defect. Allowing the doctor to prevent harm seems like a humane response, one that is reinforced by the cultural practice of assuming that if we have the science, we should use it. It is also reinforced by the perception that the fetus is an innocent bystander, threatened by the other patient's noncooperation. Where child neglect petitions are sought, the doctor testifies that the pregnant woman had the ability to prevent the harm by not drinking or by not taking controlled substances. Again, the fetus is seen as victim. This response is reinforced by the assumption that if we have the information, we should act on it. Scientifically acquired information translates too quickly into additional rights or duties when we default. It is only a secondary thought that, in order to prevent the fetal harm or repair the defect, the woman's interests must be considered. As the cases indicate, many assign the woman's interests little weight.

I have argued that the devaluation of woman's interests is attributable in part to the practice of defaulting to science. If one subtracts the assumption that science should be used, it becomes easier to imagine that one's first response to the question of forcible medical treatment or imposing sanctions for drug use during pregnancy might be to think of the woman's interests. One might still react to the potential for fetal harm, but the reaction is less adamant without the assumption that one must act. There is more room for the concern that the procedure might pose risk to the woman. Once the assumption that the woman's interests can be discounted to protect the weaker fetus is taken away, it even becomes possible to assume that the woman's autonomy interests are too important to override. I am suggesting that, with regard to the science of fetal development, the normative assumption that science should be used is incompatible with the liberation of women.

### B. *The Interventionist Mindset of Law*

The interventionist mindset of law is a readiness to use state power to address perceived moral problems by regulating the individual.<sup>479</sup> Like the assumption that science is progress, the interventionist mindset is accompanied by a failure to critically evaluate the wisdom of so acting. Many have commented on effects of this mindset—the regulatory state<sup>480</sup> and the

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<sup>479</sup> "Mindset" refers to "patterns of perception" that have "become habitual, tempting us to believe that the way things are is inevitable, or the best that can be in an imperfect world." Delgado, *supra* note 6, at 2416–17.

<sup>480</sup> See, e.g., Cass R. Sunstein, *Paradoxes of the Regulatory State*, 57 U. CHI. L. REV. 407 (1990).

devaluation of individual rights.<sup>481</sup> In this section, I will describe the impetus for using state power to address social problems as the moral failure of certain individuals or groups, as a twentieth century mindset. The regulation of pregnant women is one result of this mindset. The labeling of pregnant women as “good mothers” and “bad mothers” signifies the sense of righteousness behind the regulation.

The discussion here will center on the apparent use of state power for the management of social problems and on the impetus to manage social problems by restricting freedom of action rather than preserving it.

### 1. *The Call to Law*

The interventionist mindset at law occurs as call and response. During the nineteenth century, there was, as discussed in Part II, a fairly clear line between the private and the public spheres. Family and church provided a broad moral authority.<sup>482</sup> State power was generally reserved for maintaining public order and safety. Law might be used to defend the moral authority of the family, and it might do so by reinforcing narrow gender roles for women, as in *Bradwell* and *Muller*.<sup>483</sup> But issues such as procreation, childrearing, education, and the transmission of values were regarded as family matters, not appropriate for state regulation. They were private, not in the constitutional sense, but by social function.

During the twentieth century, as the socializing authority of family and church has decreased, the law has become more salient. The state is now regulating behavior that used to be considered private sphere matter. For example, criminal law during most of the nineteenth century moved away from using law to address moral issues as the influence of the Puritan ethic waned. During the earlier part of the century law was used to address issues that are more universally understood as crime without reference to a time-bound moral code—crimes against property or crimes resulting in bodily harm or death.<sup>484</sup> The use of law as social management began in the late nineteenth century. The

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<sup>481</sup> See, e.g., Robert Nagel, *The Formulaic Constitution*, 84 MICH. L. REV. 165, 205–07 (1985); Charles Reich, *supra* note 435, at 1417–23.

<sup>482</sup> The Social Purity Movement was in part a response to the perception that the authority of church and family were disintegrating. Schlossman & Wallach, *supra* note 106, at 85–88.

<sup>483</sup> See *supra* notes 18–35 and accompanying text.

<sup>484</sup> Lawrence M. Friedman, *A HISTORY OF AMERICAN LAW* 257–58, 508–10 (1973); Kermit L. Hall, *THE MAGIC MIRROR: LAW IN AMERICAN HISTORY* 185–88 (1989); David Ray Papke, *Law in American Culture: An Overview*, 15 J. AMER. CULTURE 3 (1992) (exploring the general proposition that Americans are inclined to approach problems in a legal framework).

regulation of female prostitutes was part of this trend,<sup>485</sup> as was *Muller v. Oregon*.<sup>486</sup> That decision provides a striking example. The Supreme Court held that states could restrict the working hours of women because "healthy mothers are essential to vigorous offspring."<sup>487</sup> Ironically, this decision was rendered during the *Lochner*<sup>488</sup> era, a time when freedom of contract was considered essential to a free society. Liberty for men apparently depended on regulation of women.<sup>489</sup>

The current regulation of pregnant women continues to use law as social management. "Healthy babies" have become a social concern and a political issue.<sup>490</sup> Women who give birth to unhealthy babies are the perceived problem. Law is used to address the issue by directly and indirectly restricting the choices of pregnant women. A moral appeal, unenforceable at law, to a woman as mother is no longer considered sufficient or politic.<sup>491</sup> Women, perhaps due to feminism, have acquired some authority to define themselves without reference to their biological capacity to bear children. The Code describes this transformation as a failure of motherhood as a private sphere institution. Thus, a call is made to bolster the moral responsibility with fetal rights and maternal duties.

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<sup>485</sup> See *supra* notes 41–56 and accompanying text.

<sup>486</sup> 208 U.S. 412 (1908). See David L. Faigman, *supra* note 22, at 560 (identifying *Muller* as the beginning of sociological jurisprudence)).

<sup>487</sup> *Muller*, 208 U.S. at 421.

<sup>488</sup> *Lochner v. New York*, 198 U.S. 45 (1905).

<sup>489</sup> See Faigman, *supra* note 22, at 561. Faigman points out that "*Lochner* and *Muller* are consistent in that they embrace a similar theory of human relations, a theory made explicit in *Lochner* but left unstated in *Muller*. This theory, generally associated with Social Darwinism as popularized in the works of Herbert Spencer, dictated that freedom of contract was to be protected against legislative intrusion except in certain categories of cases," such as women and children. *Id.*

<sup>490</sup> See, e.g., PREVENTING INFANT MORTALITY: INTERGOVERNMENTAL DIMENSIONS OF A NATIONAL PROBLEM: HEARINGS ON S.1209 BEFORE THE SUBCOMM. ON INTERGOVERNMENTAL RELATIONS, 99th Cong., 1st Sess. at 7 (1987) ("And as a nation, we value every life as special and important, no matter where the life comes from. Because of our own moral code, we have the obligation and are justified in trying to make sure every child born into our nation has a healthy start in life. We have seen from the evidence presented in this report that there are many babies who never even get a chance to be born healthy, whether out of ignorance on the part of the mother, lack of money for care before and after pregnancy, or other reasons totally separate from the physical being of the newly born child.").

<sup>491</sup> See Note, *supra* note 161, at 1334–35 ("Changes in women's role within the family and the broader shift in sexual power relations have altered the parameters of the debate over reproductive freedom, shifting the emphasis from a maternal ethic of responsibility to a model of conflicting rights.").

## 2. *The Response*

The interventionist mindset is inclined to use law for social management, and to do so in a way that reduces “choice” and “liberty.” That is, the state can act in at least two ways with regard to social problems.<sup>492</sup> First, the state can reinforce broad principles, such as privacy, speech, and religion, by preserving freedom of action—including some harmful acts—in these arenas. The assumption is that fostering these principles will strengthen individual or community attempts to address the problems.<sup>493</sup> Second, the state can dictate a detailed moral code by applying those principles in politically selective ways for the ostensible purpose of preventing harmful behavior. Increasingly, during the past few decades, the latter method has been called for and used.<sup>494</sup>

The interventionist mindset, then, is partly a failure to consider alternatives—alternative ways of understanding the problem, and alternatives to using regulation as a solution. The call to regulation has become an automatic response to social disorder. Underlying that response is the assumption that the social disorder is attributable to a particular individual or group, such that regulating those persons will solve the problem. That is, the mindset includes a preconceived approach to solving social problems. First, formulate the problem as the behavior of certain individuals, then use law to restrict the problematic behavior.

One reason regulation has appeal as a solution is that it is cheap. Regulation is cheap because it assigns responsibility for a problem to a particular group of persons. It assumes that they must pay or change. It focuses on their behavior, but does not look to the social, political, and economic context in which the behavior occurs. Regulation allows us to avoid anything but superficial evaluation of a problem. The interventionist mindset lets us

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<sup>492</sup> Charles Reich, *supra* note 435, at 1447

<sup>493</sup> See *id.* at 1412. There are other responses, but the current concept of rights and liberty dominate in law and imagination, making it difficult to assert alternatives. See, e.g., Mari J. Matsuda, *Public Response to Racist Speech: Considering the Victim's Story*, 87 MICH. L. REV. 2320 (1989); Robin West, *Restructuring Liberty*, 59 TENN. L. REV. 441 (1992).

<sup>494</sup> The proliferation of government agencies that promulgate regulations illustrates this point: Environmental Protection Agency (EPA), the Occupational Safety and Health Administration (OSHA), the Federal Communications Commission (FCC), the Consumer Product Safety Commission (CPSC), the National Highway Traffic Safety Administration (NHTSA), the Endangered Species Act, the Natural Gas Act, and the Food and Drug Administration (FDA). Civil rights laws have also been described as a regulatory scheme. See Richard A. Posner, *An Economic Analysis of Sex Discrimination Laws*, 56 U. CHI. L. REV. 1311 (1989); Richard A. Posner, *The Efficiency and Efficacy of Title VII*, 136 U. PA. L. REV. 513 (1987); see also Nagel, *supra* note 481, at 204–07 (characterizing the Supreme Court's formulaic approach to decisionmaking as regulatory).

perceive the victims of social problems as the cause. Otherwise, we might have to consider the possibility that illegal drug use, crime, and poverty are manifestations of bigger problems that might require bigger, more expensive, more inconvenient solutions. Some of these solutions might actually require the reallocation of resources, the equitable distribution of power.

Another reason regulation is appealing is that it is easy. Regulation is tangible proof that the state has done something. However, what is taken for proof that the problem has been solved is often little more than the regulation itself. Part of the mindset is a failure to review the effects of the regulation.<sup>495</sup> There is an assumption that regulation must be positive. In particular, there is a failure to consider the effects of the regulation on the individual, on the group, and on society as a whole.

### 3. *The Dynamic*

The inclination to use law as social management presents a dilemma. On the one hand, it provides a seemingly easy way of addressing social disorder—let government take up the moral slack. This presents the state with the opportunity to expand its power. On the other hand, it leaves judges, legislators, and administrators faced with complex and politically divisive issues. The dilemma sets up two very different dynamics that produce a similar effect—the complex problem is subjected to the simplifying effects of media-influenced political process. When the problem has been reduced to simple terms, cheap and easy regulation becomes a more credible solution.

One response to the dilemma of social management takes place at the gut-level of politics. The issues—addiction and dependency, high crime rates, and poverty—become political footballs. They become a source of power for politicians or groups who publicize the issues in simplistic terms in order to gain support for their ideology or their office. This has been apparent in the “fetal-abuse” cases. Prosecutor Tague not only charged Ms. Hardy with delivery of illegal substances to a minor, but he spoke far and wide on the need to punish pregnant women addicted to drugs in order to deter others from harming fetuses.<sup>496</sup> Judge Wolf not only sentenced Brenda Vaughn to 180 days in jail, he announced that he personally was going to ensure the health of her baby by imposing the sentence. More has been said in these cases about fetal life than about the realities of drug and alcohol dependency, the lack of access to rehabilitation and prenatal care, and the discriminatory prosecution of women of color. This allows the prosecutor, judge, or legislator to come to the rescue of fetus and society by cleverly describing the problem to fit existing

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<sup>495</sup> See Sunstein, *supra* note 480, at 408.

<sup>496</sup> See, e.g., Hoffman, *supra* note 334.

law, as in the *Hardy* case, or to come up with a straightforward solution—like requiring pregnant women to avoid certain risks, as in the *Vaughn* case.

The other response is intentionally less visible. The second type of simplification occurs by the use of formulas developed to distance the judge, legislator, or administrator from the controversial nature of the issue. Generally, courts develop these formulas with the ostensible purpose of guaranteeing a neutral outcome. Legislators and administrators often adopt a formula to validate their lawmaking.<sup>497</sup> However, formulaic lawmaking actually facilitates value-based social administration. It directs attention to the form and the results of lawmaking, rather than to the process and substance of the laws.<sup>498</sup> Once a neutral-sounding test, standard, or rule has been articulated, we relax in the belief that the formula dictates a neutral, objective outcome. That is, neutral-sounding formulas mask the value judgments made while applying the formula.

The formulaic approach to constitutional decisionmaking is a twentieth century development.<sup>499</sup> The approach developed as constitutional standards came to be used extensively to distinguish between acts that should be subject to state regulation and acts that should remain free from government interference. Now, instead of a rigid social structure, we have the freedom of expression, religious freedom, equal protection, the right of privacy, the concepts of police power and *parens patriae*, and important or compelling state interests. Despite the use of formulas to limit the scope of these legal doctrines, they have proven plastic, so that it now seems frighteningly easy to shrink the sphere of protected privacy, and to establish a regulatory scheme.<sup>500</sup>

Privacy, as discussed in Part III, invokes a balancing test.<sup>501</sup> In formulaic terms, the state cannot restrict the woman's interests in bodily integrity and decisional autonomy unless it has a sufficient state interest. Empowerment is inextricably tied to privacy; autonomy is impossible for the subordinated. In other words, those deprived of power cannot make real choices. Yet, the formula does not expressly incorporate an equality principle,<sup>502</sup> rather it simply assumes that each person has the ability to choose from the same set of options. Thus, where this type of equality does not exist, the outcome is imbalance, obscured by the formula.

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<sup>497</sup> See e.g., GA. CODE ANN. § 16-12-141 (Michie 1988); IND. CODE ANN. § 35-1-58.5-1 (Burns 1989); MO. REV. STAT. § 188.029 (1992); S.D. CODIFIED LAWS ANN. § 34-23A-5 (1986).

<sup>498</sup> Nagel, *supra* note 481, at 195.

<sup>499</sup> *Id.* at 165.

<sup>500</sup> See *id.* at 202-03; Reich, *supra* note 435, at 1430.

<sup>501</sup> See *supra* notes 232-48 and accompanying text.

<sup>502</sup> For an approach to autonomy that explicitly incorporates equal protection, see Roberts, *supra* note 104, at 1476-82.



The problem is that attention shifts to the structure, the formula.<sup>503</sup> It patently provides for two sides to be heard in the balancing. The formula appears neutral. It was crafted by judges who purport to stand in the place of Blind Justice. So, like science, it is assumed to be a truthfinder. The interests at stake become merely items to be plugged into the formula. The formula, however, ignores the process through which interests become important enough to be weighed. That process is political. Nor does the formula adjust for shifts in political power that affect the outcome. For example, consider the debate over the right to decide whether to terminate a pregnancy. When the Supreme Court decided *Roe v. Wade*<sup>504</sup> and recognized that women have certain authority over their own lives, women as a group were politically ascendant. Women's autonomy interests were accorded significant weight when the formula was applied. Since then, the political balance has shifted to conservative, and so have the outcomes under the formula.<sup>505</sup>

The debate has focused largely on whether recent decisions erode the *Roe* trimester analysis. The trimester balancing test has become both an icon and a bugaboo. For some, *Roe* is an icon for sexual equality and the concomitant right of women to control their bodies and their lives. For others who are pro-life it represents a disregard for humanity. *Roe* has become a bugaboo in the way it has shaped the debate. The ostensible debate is about the formula, yet the formula has taken on such significance that any time it is modified victory is declared for one side and defeat for the other. But the formula only explicitly addresses a woman's right to decide whether to terminate a pregnancy. It does not say that women have an interest in controlling their lives. The formula does not overtly acknowledge the impact of state restrictions on women as a group, or on society. But that is what the debate is really about—who controls the formula.

The debate takes similar shape when state restrictions infringe upon choices other than pregnancy termination. In the discussion over the regulation of pregnant women, much of the legal analysis has centered on whether the *Roe v. Wade* trimester analysis is appropriate in a forced medical treatment or drug use case. The formula and weight used in these situations indicates that those who would regulate women are in control. The list of state interests deemed sufficient to override choice has expanded. As the cases in Part III show, the courts may now regard potential life, a future right to be born with a sound

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<sup>503</sup> See, e.g., Faigman, *supra* note 22, at 575–76 (critiquing Justice Blackmun's opinion as a judicial exercise in skirting the issue. "Using the trimester framework, the Court finesses the perhaps intractable problem of expounding the many conflicting principles and value choices comprising the fundamental right of privacy in the abortion context.").

<sup>504</sup> 410 U.S. 113 (1973).

<sup>505</sup> See *supra* note 94. The Court has not only reweighted the interests in favor of state control, it has also changed the formula from strict scrutiny to an undue burden analysis.

mind and body, and a maternal duty to care for the unborn child as valid state interests.<sup>506</sup> The list of individual interests has not expanded, while the number of regulations has.

The problem with the interventionist tendency to simplify by focusing on the formula is that the terms of the formula constrain the debate. It is difficult for those trying to eliminate subordination to gain ground with a formula that assumes equality. A debate about the formula enhances the authority of those who control the formula. It predetermines the issue—control, and the conclusion—regulation.<sup>507</sup>

### *C. Converging Forces: The Ideology of Motherhood, The Practice of Defaulting to Science, The Interventionist Mindset of Law*

The regulation of pregnant women is converging at the intersection of the ideology of motherhood, the practice of defaulting to science, and the interventionist mindset of law. A synergy among these forces exists that makes it difficult to attribute specific parts and moments of the regulatory scheme to any one force. I simply want to evoke some sense of the dynamic in play.

The ideology of motherhood, as mentioned in the introduction, focuses the power of the state on women, and does so in a way that categorizes women as mothers. Science as authority provides a neutral-sounding rationale for using state power. The readiness to use state power to subordinate, rather than to liberate, enhances the standardizing and punitive power of the motherhood ideology.

For example, when physician participation in childbirth became standard, the doctor gained control of the birth process. And obstetrics, the science of pregnancy, gained the authority to raise questions about medical intervention and answer them affirmatively. Obstetrics became a participant in the ongoing project of defining women as childbearers because of the practice of defaulting to science. The ideology is co-opting.

When we assume that science is neutral and disinterested, that it is apolitical and has authority only as a source of truth, we become blind to another truth—that knowledge is power. When we recognize science as truth and authority, we institutionalize it. The practice of defaulting to science has become canon. And when we fail to understand that institutions in a power-imbalanced world perpetuate hierarchy, we cede the autonomy of those marginalized by the hierarchy to those who control the institutions. By giving the institution of science the authority to raise questions and to answer them,

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<sup>506</sup> See *supra* notes 379–81 and accompanying text.

<sup>507</sup> See Ikemoto, *supra* note 144, at 498–99.

we subtract from the ability of the individual to do so.<sup>508</sup> We remove the individual from the dialogue. Thus, when obstetricians raise the question of whether or not to perform cesareans and obstetricians decide to perform them, then the notion that good mothers should consent to surgical intervention is added to the ideology.

The norm requires respect from individuals. When a woman acts or chooses in a way that defies that expectation, her act or choice is devalued. Because we default to science, when obstetrics speaks, we assume the message is rational. When obstetricians say a purse-string operation is necessary to prevent miscarriage, we assume consent to the operation is the rational choice of every woman. The woman who refuses consent, who defies the "truth" that her refusal endangers the fetus despite her doctor's concern, must be thinking irrationally. In ideological terms, the woman has failed to listen to reason, and her decision is selfish; a woman who makes a selfish choice is an unnatural mother.

With regard to the regulation of pregnant women that is not imposed as medical treatment, but is more clearly punitive in nature, authority still issues from the institution of science. That is, scientifically acquired knowledge about fetal development, about the effects of drugs, alcohol, and other toxins and behaviors, provide the reason for directing state power at women. It casts the use of power in a reasonable light. It contributes to the normative, conformist, fault-imposing character of authority in a hierarchical state. The indirect regulations also result when the ideology of motherhood is applied in conjunction with the authority of science.

The interventionist mindset reinforces the notion inherent in the motherhood ideology that "the problem" defined by science is attributable to women, not to the institutions of power. In response to the call to law, women who defy the norm are sanctioned by the state. The irrationality of the response is not obvious, however, because the process of responding with regulation is apparently neutral. The process of applying neutral-sounding formulae shifts attention to the structure of the process rather than to its substance and results. It seems rational to find that the state's interest in protecting potential or fetal life outweighs the woman's interest in autonomy, when one does not have to think about how those interests were identified and assigned a weight.

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<sup>508</sup> See ARONOWITZ, *supra* note 436, at 3–34 (discussing "science and technology as hegemony"); Harding, *supra* note 453, at 16. See generally ANDREW FEENBERG, *CRITICAL THEORY OF TECHNOLOGY* (1991).

## V. THE UNIVERSAL STANDARD OF GOOD MOTHERHOOD AND THE COMPLEX OF DEVALUED MOTHERHOOD MODELS

The ideology of motherhood directs the power of the state at women with regard to pregnancy, and it does so by linking two other faces of patriarchy—the practice of defaulting to science and the interventionist mindset of law. This makes “fetal interests” a code word for legalized subordination. The resulting “Code of Perfect Pregnancy” becomes part of the ideology. Motherhood becomes a code used to limit access to power to the few who hold the key.

The ideological construct of motherhood consists of multiple models. This article has focused on the “Good Mother” model, but has only suggested that other models operate simultaneously. These are the negative models, the ones that form the “Bad Mother.”

The Good Mother tends to be used as a universal standard. It is applied to all women in a way that ignores the social reality in which they live. The regulatory approach constrains us to talk in terms of fetal rights and maternal duties. It permits no exploration of conflicts resulting from the unequal distribution of political power and social goods. The regulatory approach does not require those applying the standard to remember that poor people have little access to prenatal care or that certain medical procedures violate religious convictions. Nor does it take into account that some patient decisions originate from fear and misunderstanding perpetrated by the medical professionals, that persons addicted to drugs or alcohol cannot simply stop, and that pregnant women are seldom admitted to substance abuse rehabilitation centers.<sup>509</sup> This approach does not require those applying the standard to explore how they have experienced race, class, and gender, or how the experience of subordinating might lead them to assume that certain women will be good mothers and certain women will not.<sup>510</sup> Nor does the use of “fetal rights” reflect the wrongs suffered by women when regulation is imposed. In other words, the universal standard does not allow us to look beyond “bad mothers” for the “real” causes of social problems.

The result is a regulatory scheme that tells women to be good, to act selflessly, to protect children, and to ensure a healthier, more economically

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<sup>509</sup> See Mari Matsuda, *Pragmatism Modified and the False Consciousness Problem*, 63 S. CAL. L. REV. 1763, 1764 (1990) (arguing that we should listen “long and hard to less privileged voices” to rectify “historical devoicing.” Such listening is “restitutional, reparational, rectifying, and reconstructive. It is the antidote to . . . the situated knowledge of the golden few.”) (citation omitted).

<sup>510</sup> See Robert A. Williams, Jr., *Gendered Checks and Balances: Understanding the Legacy of White Patriarchy in an American Indian Cultural Context*, 24 GA. L. REV. 1019, 1021 (1990) (“[T]his common tendency ‘to treat one’s own perspective as true, rather than as one of many possible points of view,’ is particularly complicated by the continuing and pervasive legacy of four centuries of white patriarchy in our society.”) (citation omitted).

productive future for society. In terms revealed by explicating the general standard, the regulatory scheme tells women to subordinate their own interests to those identified by others as more important.<sup>511</sup> The possibility that their failure as individuals is a conclusion imposed by the dominant culture is not admissible. Those who cannot be good given their social reality, or those who cannot be perceived as good given the cultural stigmas attached by those who control the standard, are blamed for the problems.

A description of the other mother models requires a complex analysis of the motherhood construct along race, class, and other lines of subordination. That is part of the continuing project. However, I would like to suggest the beginnings of such an analysis in order to push the project of enacting a concept of liberty that denies the possibility of subordination.

The ideology of motherhood has a very particular form. First, it distinguishes between white middle- and upper-class women, and women oppressed by race, poverty, cultural elitism, heterosexism, etc. White middle- and upper-class women are part of the sector that defines the norms. Thus, these women *are* the Good Mothers. Even the white middle- and upper-class women who defy the norms are not necessarily Bad Mothers under the ideology. The “bad” label is generally reserved for members of the outgroups. Thus, those who defy the norm are usually considered Good Mothers gone astray.

The ideology holds outgroup women to the Good Mother standard and, at the same time, to often contradictory and always devalued models of motherhood particular to women of color, poor women, and women from other oppressed groups such as lesbians. There is a complex of devalued mother models working against outsider women.

Outgroup members are presumptively not Good Mothers. But they are presumed to fit within one or more of the devalued mother models. An outgroup woman can never completely conform to the Good Mother model because of her race, class, culture, or other orientation. Even the outsider who conforms to that extent is never a Good Mother. She will still be devalued. Some may say that she is extraordinary because she overcame her race or class, but not because she overcame racism, classism, cultural elitism, or heterosexism, to become a Good Mother. But the indicator of her outgroup status will not be part of her achievement.

A member of an outgroup who does not conform to the Good Mother standard to the extent that she is not privileged may still be a Good Black Mother, or a Good Welfare Mother, or a Good Hispanic Mother, or a Good Asian Mother, but under the ideology, those models are not quite as good as the Good Mother. Thus, there is a Good Black Mother model, but there is no

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<sup>511</sup> This is similar to the effect of not acknowledging procedural racism described by Richard Delgado. *See* Delgado, *supra* note 476, at 105–09.

such thing as valued Black motherhood. The devalued goodness of these models confirms the superiority and justifies the privilege of the in-group.

Those women who cannot conform to any of the good mother standards are the Bad Mothers. That is, their noncompliance is presumptively willful and morally incorrect. These women are not bad mothers simply because they have failed to fit existing Good Mother models, but also because they do fit existing Bad Mother models. They confirm the expectations of failure that justify white middle-class privilege.

These devalued mother models operate in even more complex ways. If an outgroup woman conforms to a good outgroup mother model, she may overcome her presumed potential for bad motherhood, but not necessarily. Thus, Black women are perfectly acceptable as surrogate gestators for white women's children. That is one Good Black Mother model. However, she may still be regarded as only capable of raising her own children to be juvenile delinquents. When Black women raise "good" children, the children are more often than not regarded as extraordinary; they are said to be extraordinary because they have overcome the blackness of their mothers, not because of what they have achieved in the presence of racism.<sup>512</sup>

This is not a conclusion. It is the beginning, I hope, of a continuing project. It is time to break the Code.

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<sup>512</sup> See, e.g., *BOYZ IN THE HOOD* (Columbia Pictures, 1991).